HEALERS IN THARAKA

A Case-study of the Development of a Professional 'Jurisdiction'

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ABSTRACT

The thesis examines the process of social change among Tharaka agao (healers) in the Meru District of Kenya: it analyzes the rationale of the social and cultural processes involved for an existing occupation to become a recognized professional activity in modern Kenya. The thesis argues that a radical redefinition of professional 'jurisdictions' is required in the medical field. The concept of 'jurisdiction' is discussed here in metaphorical terms in order to question the common assumption that professionalization in the Western-type is the only possible model of developmnent for African healers.

The first part of the thesis, after information related to the structural and cultural context of Tharaka, provides an overview of the Tharaka experience of management of illness, with an emphasis on health-seeking behaviour and the division of labour in health care. The second part establishes the cultural boundaries of the healing 'jurisdiction' of the Ugao and the mechanisms used to gain the claimed control over it: this is done by presenting and analyzing the ethnographic material which I collected during a period of apprenticeship with three Tharaka healers.

The third part investigates the social dimension involved in the development of that 'jurisdiction', by examining group formation among healers and the problems generated within the emerging profession. It also considers the matter of integration of Tharaka healers within the local health care system through an analysis of their interrelationship with the biomedical personnel and the health care facilities. Finally, it discusses the problem of legitimation the whole process of professional development raises at the local and national level.

PREFACE

I collected the substantive material for this dissertation over a period of about nine years, form 1984 to 1993: twenty-nine months of which were spent directly in the field, within the overall framework of the Tharaka Rural Health Care Programme (THARCAP) run by the Italian non-governmental organization C.U.A.M.M. (University College for Cooperation in Developing Countries) in the Meru District of Kenya. This is not a detailed account of the Programme itself: I have selected only a particular aspect of it, focusing on the problem of the development of indigenous medicine. Given this focus, I have analyzed my field material within the framework of medical anthropology, with the contribution of other disciplines, particularly the sociology of the professions. This means that this is not just an ethnographic account of a particular case-study, but it would also aspire to be a contribution to a comparative perspective on medical professions, with particular regard to the problem of their development in a context such as the present African one.

I have also made reference to both primary and secondary sources related to my research problem, all of which are listed in the bibliography: they were consulted or borrowed from the University of Nairobi's and Institute of African studies' libraries in Kenya; from the University of Bologna 's library; and from different libraries in London (UCL, SOAS, London School of Economics, Wellcome Institute for the History of Medicine, London School of Hygiene and Tropical Medicine) and in Cambridge and Oxford.

Guido Giarelli

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Secondly, many thanks go to the Italian non-governmental organization C.U.A.M.M. (International College for Health Cooperation in Developing Countries), and particularly to its directors D. Luigi Mazzuccato and Prof. Anacleto Dal Lago, who granted financial support to the Programme, sharing its aims and methods and appreciating their significance for a new approach to the problem of development and international cooperation in Africa.

Thirdly, special thanks are due to all the medical personnel who willingly collaborated in the implementation of the Programme, and particularly to the Italian doctors of Nkubu Hospital who actively took part in the development process and cooperation system described in the work.

Fourthly, this dissertation would not have been written without the full cooperation of Tharaka people, and particularly of all the indigenous health practitioners I met. My long stay with them allowed me to understand many aspects of their professional work; and a special gratitude is due, in this respect, to my master M'Mburuki and his two assistants Kinyua Nkoru and Rukungi Mungania, who initiated me into the secrets of the Ugao.

Fifthly, I have a special debt for the selflessness, which they all showed in their work, of my field assistants Joseph Chabari Mugao, Josaphat Kiria Kanake, Alex Muthengi Muchee and Stephen Simba Njagi. Particular gratitude also goes to Januarius Marie Riungu, headmaster of Nkubu Primary School, who supervised the work of my field assistants and discussed with me at length many of the issues contained in the work.

Finally, I owe an enormous debt to my tutor Dr. Murray Last, who patiently and indefatigably followed the birth and growth of this work step by step; his critical guidance throughout the writing proved to be valuable in leading me to a full appreciation of the meaning of scientific work. Special thanks also go to Prof. Bernardo Bernardi, who continued to follow my work even after my graduation, supporting it with his suggestions and valuable field experience of Tharaka and Meru since the fifties.

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EASTERN

RIFT

VALLEY

NORTH

EASTERN

WEST.

MERU

DISTRICT

NYANZA

CENTRAL

NBI

EASTERN

COAST

HARAMBEE

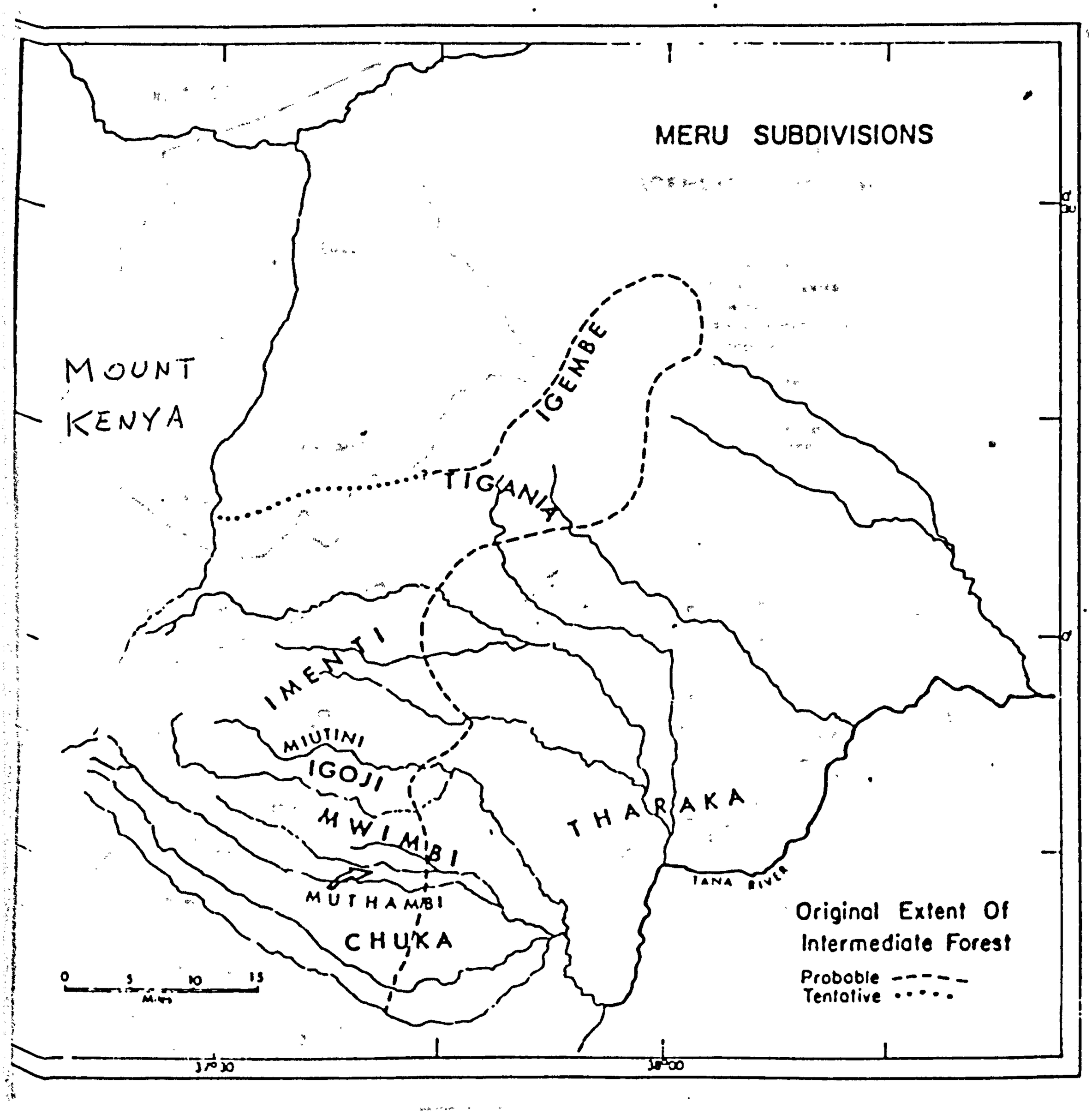
Administrative boundaries

——— Provincial boundaries

— NBI — Nairobi area and City

——— Meru District boundary

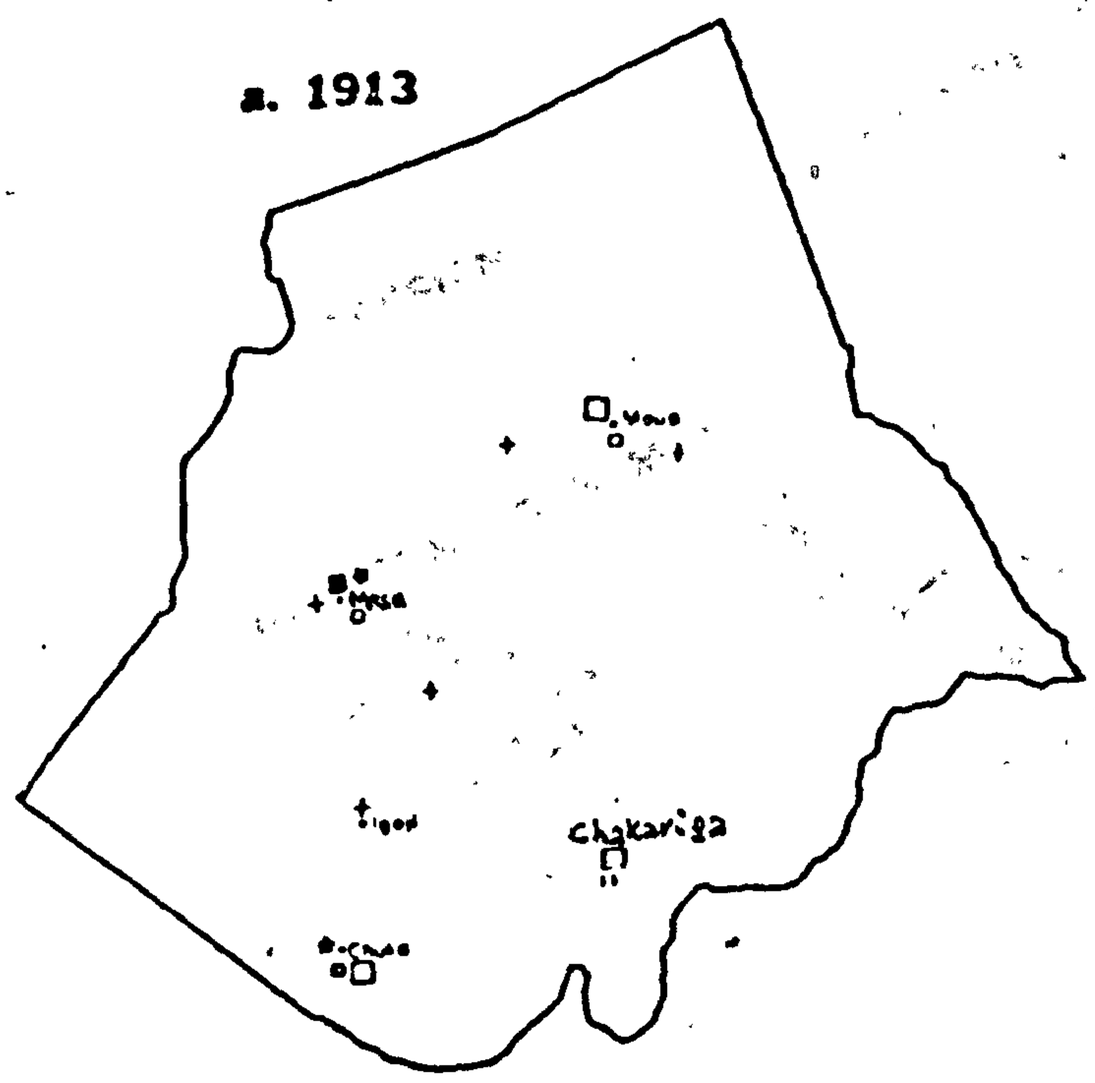
Map 1 KENYA


MERU SUBDIVISIONS
MOUNT KENYA
IGEMBE
TIGANIA
IMENTI
MIUTINI
IGOJI
MWIMBI
MUTHAMBI
CHUKA
THARAKA
TANA RIVER
0 5 10 15
M.ms
Original Extent Of Intermediate Forest
Probable
Tentative

MAP 2

MERU DISTRICT
AGENCIES OF CHANGE

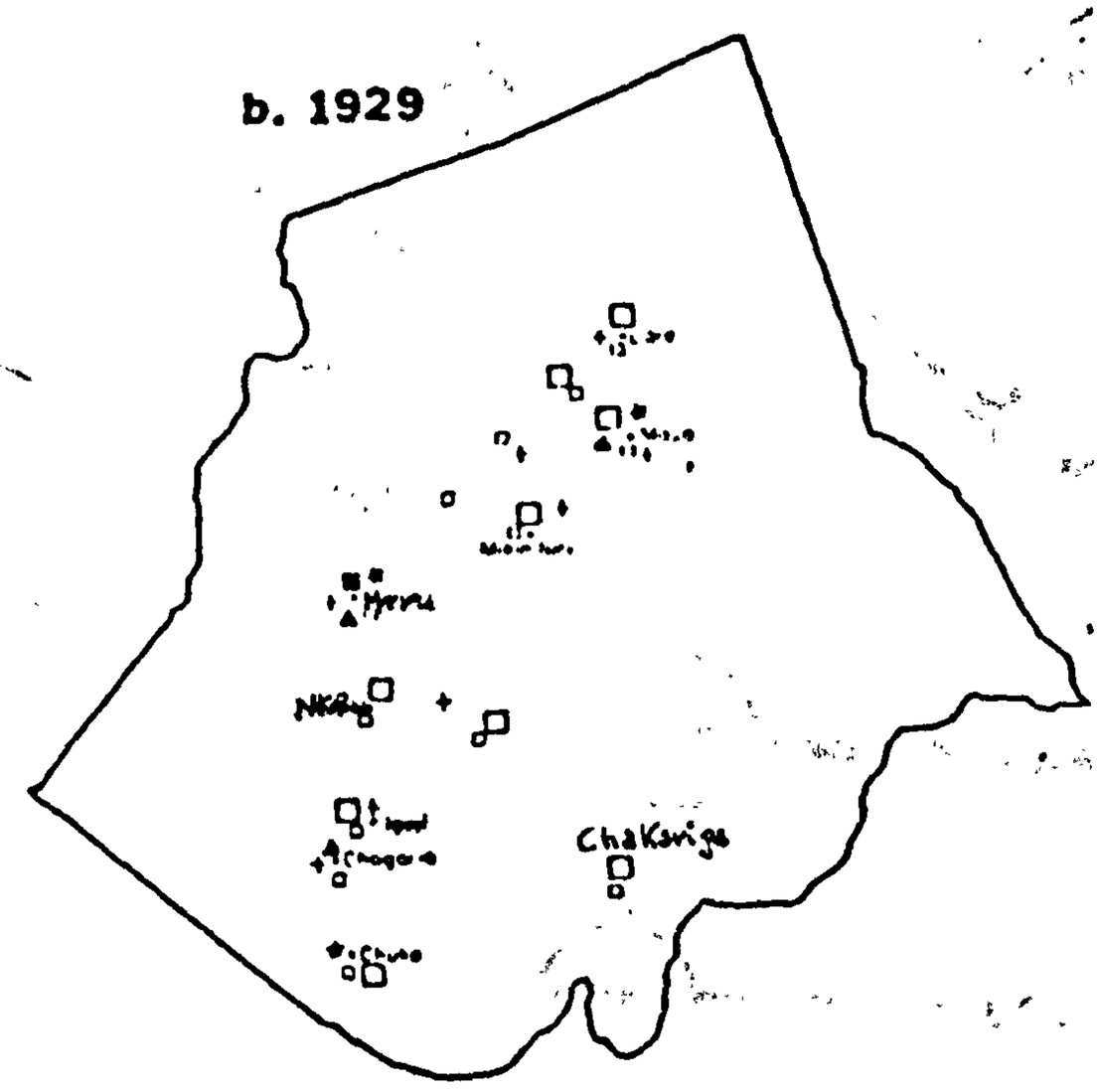
a. 1913



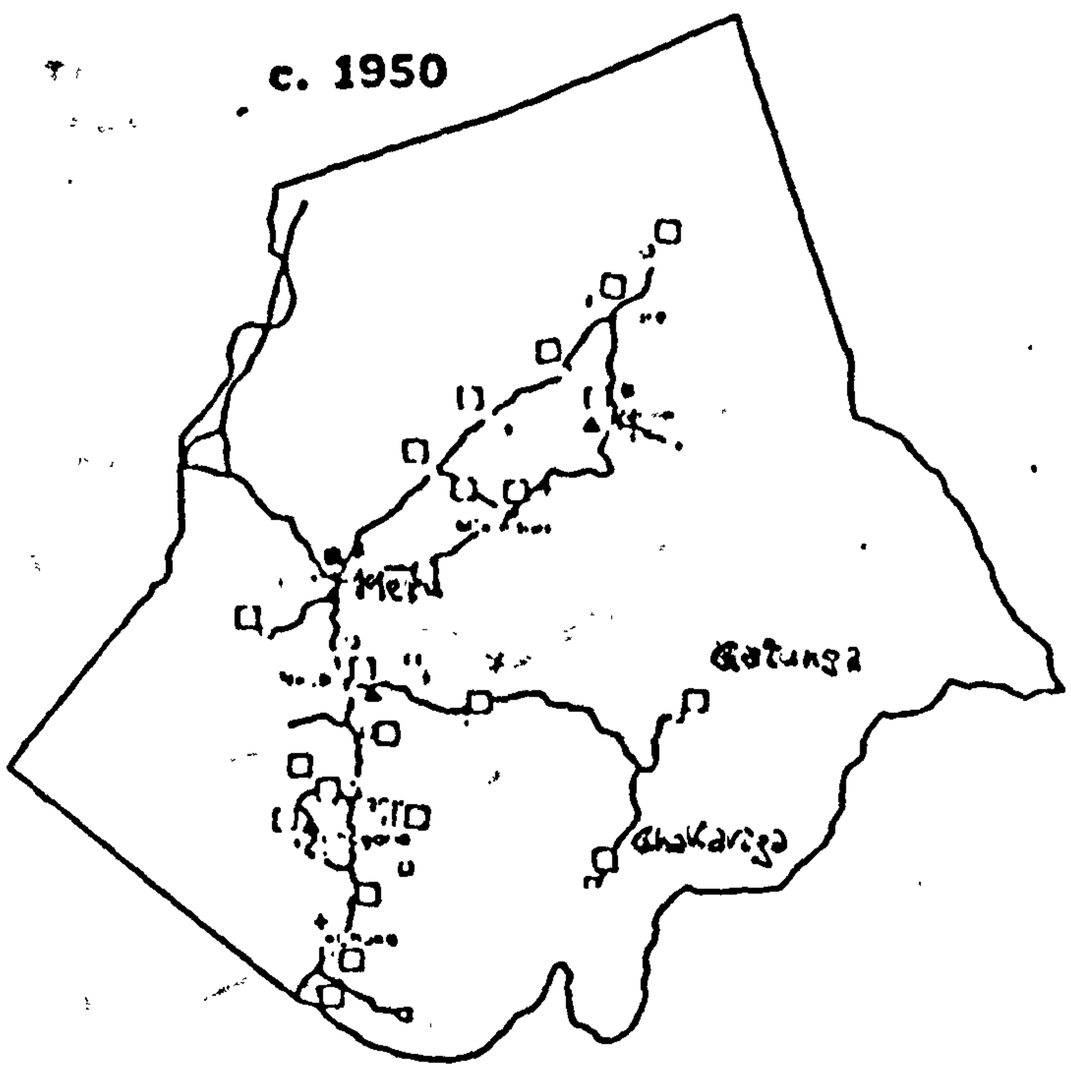
- TOWNSHIP
- TRADING CENTER
- MARKET
- GOVERNMENT STATION
- MISSION
- HOSPITAL
- MAIN ROAD

0 5 10
miles

b. 1929

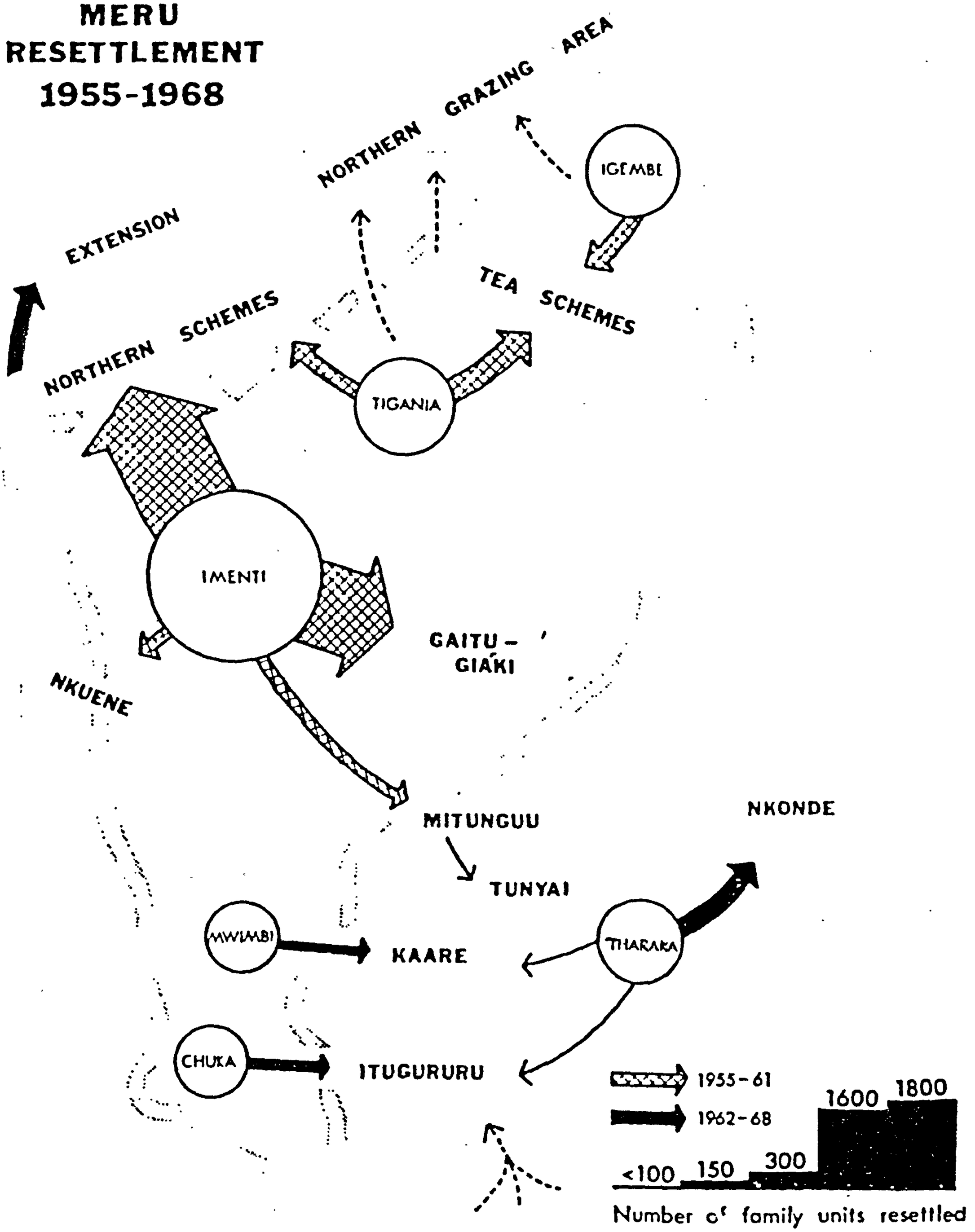


c. 1950



MAP 3

MERU RESETTLEMENT 1955-1968



MAP 4

NORTH IMENTI
KATHERI
ADOTHUGUCI
ITHANGO
KITHIRUNE
MARIENE
RUGA
GATIMBI
GAITU
Gaitu
KARIENE
KAONGO
KIBGU FOREST
KIAMURI
URUKU
NKUENE
KATHERA
IGADE
MWANGATHIA
MAKANJORE
NKUBU
MIKUMBUNE
GITIE
UPPER CHURE
ABOGETA
NGO'NY
MITUNGUN
Mitunguu
UPPER KITANGIRI
KANYARWE
KANYAKINE
KIRUGA
MITUNGUU
UPPER KIUNGONE
SOUTH IMENTI
KIJORO
MWERU
KIAIJOGU
MITENE
Igoji
KARIA
IGOJI
GIKUI
CHOGORIA
Chogoria
KIRARU
MAGUTUNI
THIGA
NJUGUNI FOREST
MWIMBI
MURUGI
KIERA
MUGUMANGO
MUTHAMBI
KARIMBA
KANDUNGU
MUTINO
NITHI
chuka
MARIANI
Kanjeki
KARINGANI
KANJUKI
KITHANGANI
KAMAINDE
KAMWIMBI
MAGUMONI
KADYURU
Nkondi
NKOUDI
THURIMA
Thurima
Mitunguu
Marimanti
CENTRAL MARIMANJI
THARAKA
Tunyai
TUNYAI
SOUTH THARAKA
NTUGI FOREST
KISEGGE FOREST
CHAKARIGA
chokariga
Materi
MWEERA FOREST
KAMANYAKI
NORTH THARAKA
KANJORO
KATHANGACHINI
KIKINGO FOREST
Gatunga
GATUNGA
THARAKA
MARIMTINI FOREST
GATUE
MUTEJEWA FOREST
DIVISION
LOCATION
SUB-LOCATION
SCALE 1:200·000
Map 5

SCALE 1:200'000

NORTH-THARAKA-LOC

KANJORO

GATUNGA

KATHANGACINI

GATUE

(Gatithini) Gacibine MKt

Thangaca

Miiti

Thangaca sch

Nkumaro

Fariani sch

Kiumurende

Ciambaratic

MUKOTHIMA MKt sch

Ura

URAGA sch

NYORA sch

00°00'

MAUTHENI sch

Irunduni sch

Thanantu

MUKUTHU (Ireren) sch

KYUMBE

Kauthani

GAKAONI sch

MANTHI

Kiangombe sch

Gikingo forest

Thangata

Kathangachai sch

1500

TANA

3584

3000

2500

2000

Kinunko

GATUNGA Sch MKt

Kagocwani

Kamatumo

Kiriakamboro

Kinuko

NDICIANI sch

Gituge sch

Ngotha

2123

2969

Ngotha Forest

Ntungu Rock

2231

Iruma Sch

MANDURU

MARAGWA sch

M. tejwa Forest

2500

Kethongoro

Kamwathu sch

Kamagena sch

Thanantu

Kachico

TANA

38°10' East of Greenwich

38°15'

MAP. 6

NORTH THARAKA HEALTH CARE FACILITIES

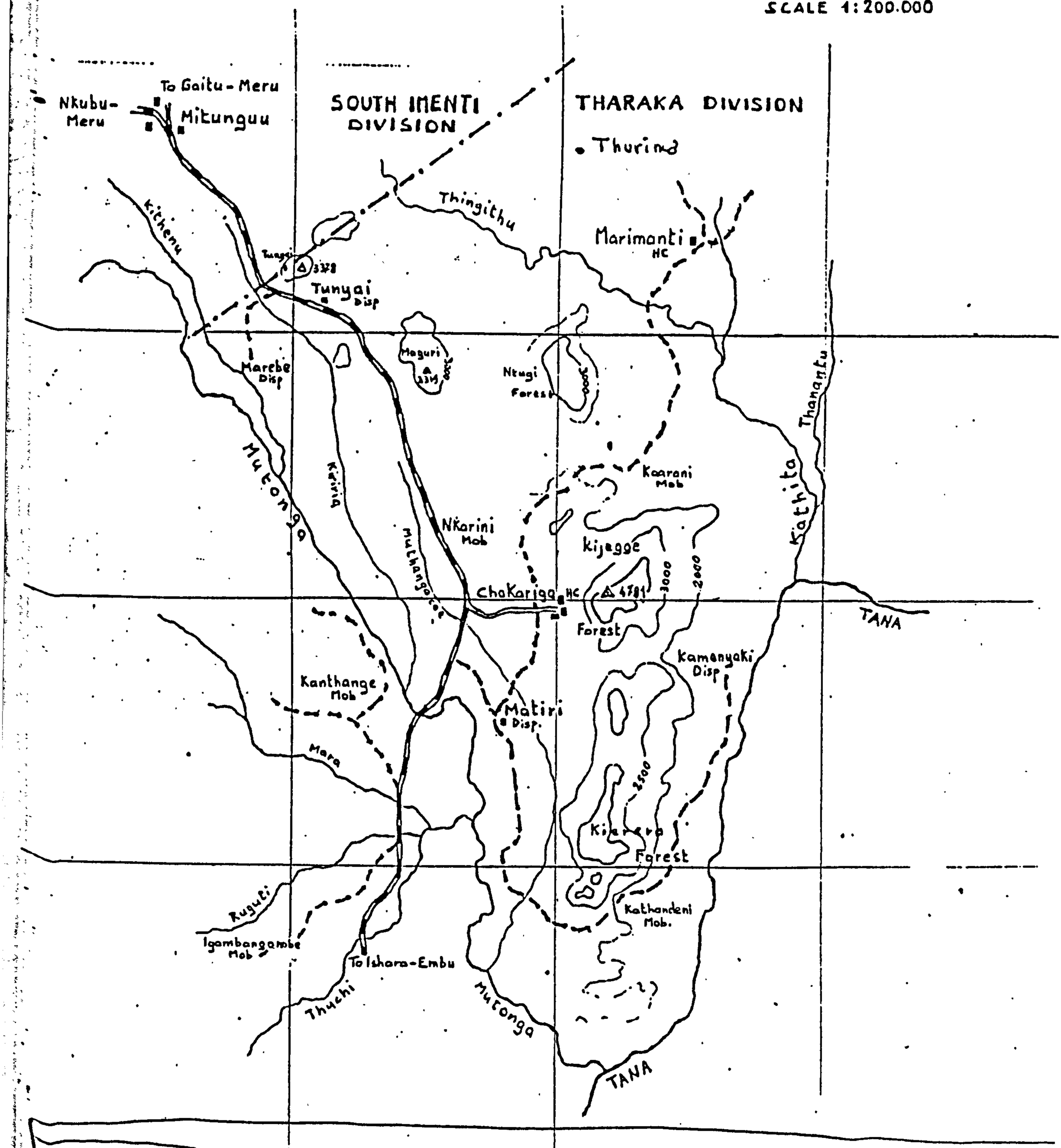
- Government Dispensary
- Catholic Dispensary
- MCH mobil clinic
- RH program
- mobil dispensary
- sch school ; MKt market

main road ; motorable track (4 wheel drive) ; footpath

location boundary ; district boundary

ALTITUDE 1000 1500 2000 2500 3000 3500 FEET
305 457 610 762 914 1067 METRES

SCALE 1:200.000



MAP 7

HC: Health Centre Disp: Dispensary Mob: Mobil clinic

CENTRAL AND SOUTH. THARAKA HEALTH CARE FACILITIES

INTRODUCTION

0.1 The Research Problem

Shortly after the advent of Independence, most African countries felt the need to rediscover their traditional cultural identity; and 'Traditional Medicine'(1), as an integral part of their heritage, benefited from this return to the original sources. It was steadiliy starting to recover its precolonial status, because people, particularly in rural areas, had never stopped making use of it, despite the introduction of biomedicine by colonial authorities and missionaries.

There were other, more practical reasons, occurring concurrently in many parts of Africa also: health care facilities were unequally distributed between urban and rural areas; economic circumstances (lack of sources of finance, foreign debt,etc.), moreover, made imported technical supplies and drugs less and less accessible, forcing African governments to consider the possibility both of using traditional medicine to improve the health situation and of reducing national drugs importation bills by a tradition-based, self-produced pharmacopoeia.

At the level of inter-governmental organizations, the Organization for African Unity (OAU) was the first to be interested in traditional medicine, with a symposium on medicinal plants and African pharmacopoeia organized in Dakar in 1968. An Inter-African permanent commission on the same topic directed by Dr. Sofowora was set up within the Scientific and Technical Council for research of the OAU, to stimulate and coordinate research activities in various laboratories of Africa.

Another inter-governmental structure which groups together francophone African countries, the Counseil Africain et Malgache pour l'Enseignement Superieur (CAMES) whose general secretary was Prof. Ki-Zerbo, has organized many scientific colloquia on African medicine and pharmacopoeia since Lome' in 1974.

The characteristics and limitations of these early historical milestones are well depicted by Gilles Bibeau who labeled them 'the chemical line' (Bibeau,1979), meaning the identification made by the former agencies between traditional medicine and medicinal plants and pharmacopoeia: the almost exclusive presence in them of botanists, chemists and pharmacists, precluded a more comprehensive approach towards the medicine of the healers. As MacCormack also suggests:

> 'Indigenous medicines are seen as raw materials from which chemicals might be extracted for national use. Chemicals will be extracted with technological apparatus, separated from all therapeutic ritual to practitioners and patients alike. They become a product. Once medicines become pills, local people no longer command the meaning of those medicines and are made more dependent'(MacCormack,1981:424).

A significant step beyond the reductionism of the 'chemical line' was done by the WHO Regional Committee in Brazzaville, which held its twenty-sixth session in 1976 on the topic of 'Traditional Medicine and its role in the development of health services in Africa' (WHO,1976). For the first time, African traditional medicine (2) was officially considered as a complete system of medicine with original concepts and practices, and as a mine for health personnel to be used in the domain of public health. This new approach must be situated against the background of the new health policies proposed to state-members by the WHO:

the search for alternative models of health care during the 1970s (Diukanovich and Mach,1975), had in fact led to the consideration of the contribution of traditional health care within the wider WHO strategy of 'Primary Health Care' for the attainment of 'Health for all by the year 2000' (Mahler,1975). This integrated approach was further endorsed by the International Conference on Primary Health Care, held in Alma-Ata in 1978, whose well-known 'Declaration' discussed the role of traditional medicine in PHC and made recommendations for the promotion and development of traditional health practitioners 'where appropriate' (WHO, 1978).

What, in concrete terms, did this new policy really mean? The participants to the above session of Regional Committee for Africa of WHO proposed some measures:

'- registration of all traditional healers by a census;
- promotion of a corporate organization of traditional healers(...);
- legal recognition of traditional healers on the basis of tests to evaluate their competence;
- further research on traditional medical knowledge;
- possible integration of traditional healers in the health teams ' (WHO,1977).

Even though the word 'profession' is not explicitly mentioned, it is quite clear that it is some sort of professional development that the participants had in mind when talking about 'registration','corporate organization', 'legal recognition' and 'possible integration' of traditional healers. Nevertheless, the absence of such terms seems to be particularly significant when we turn from abstract ideas to practice: apart from some few substantial development, in fact - as for example the recognition of professional associations in some countries such as Benin,

Ghana, Mali, Zaire and Zimbabwe, and the formulation of new policies and legislation provisions in countries such as Niger and Zambia - the measures suggested have seemingly got no strong support or have even been deleted. In the majority of African countries - as in the other developing countries - traditional health practitioners are still not formally recognized by governments. However, in many of these countries, traditional midwives or 'traditional birth attendants' (TBAs) are being increasingly trained and utilized with proven success in PHC programmes (3).

This is probably a significant outcome of what we can term the 'public health line'; but why has the PHC strategy resulted in promoting only the training of TBAs and not of all traditional health practitioners in general ? We can guess that the latter option met much strong resistance both from African governments and from the medical establishment, whereas the former option did not create particular problems, simply implying the training of a new type of health auxiliary at the bottom of the medical staff hierarchy. This opinion is supported by a WHO report, which admits:

> 'Almost everywhere, attempts to upgrade the skills and knowledge of traditional health practitioners and to mobilize them to play an effective role in the health system have met with resistance from organized groups of health professionals with vested interests in maintaining the status quo' (WHO,1985:6).

Full integration of healers of different medical traditions is much more problematic because of the incompatibility of the different paradigms in African folk medicine and scientific medicine. Therefore, the issue of integration of traditional

healers is reduced - in practice - to the question of subordination to a dominant medical paradigm.

Moreover, 'the dangerous tendency of wanting to transform the traditional medical practitioners into mini-nurses is present everywhere in the WHO texts' (Bibeau, 1979:184). Yet, the actual social status of many traditional healers within their communities is in most cases likely to be higher than the one they could achieve through integration into the national health system as an auxiliary: so, why should they ~~accept~~ agree to collaborate?

To sum up, my research problem revolves around the unanswered question of why in most cases the new policy of integration of traditional medicine has not been implemented by African governments. Both the 'chemical' and the 'public health' line have substantially neglected the central issue of a real professional development of African healers, since they were not really interested in it, although for different reasons.

In this respect, pertinent research questions are: 1) To what extent are African healers willing to be integrated into modern health care? And under what form ? 2) What are the social and cultural processes involved for an emerging occupation to become a recognized professional activity? 3) Is professionalization on the Western model the only possible type of professional development for African healers ? 4) And if not, what could be the most appropriate kind of development for 'local medical traditions', which is what, for the most part, the majority of African indigenous medicine is ? 5) What degree of

professional development already exists in such traditions, well-rooted both in people's behaviour and in healers' work, and is it in danger of being destroyed by inappropriate exogenous forms of 'professionalization' ?

My research hypothesis entails that, if the professional development of African indigenous medicine is not simply a fashion or a matter of lip-service, it requires more than a series of purely external decisions to be implemented: it must necessarily be grounded in the internal ways of thinking and practicing the art of healing within African medicine itself. Otherwise, it will inevitably remain a totally extraneous form of intervention for those it is supposed 'to develop'.

Moreover, a real development process, like any other process of 'oriented social change' (4), should take seriously into account the problem of attitudes and mutual perception of all the social actors involved: in this case, mainly the healers, the medical personnel and the community surrounding them. As a WHO report states,

> 'Involvement and cooperation with the national health system hinges delicately upon the attitudes of professional health workers and administrators at all levels of the health system, the willingness and confidence of traditional practitioners to learn and exchange experiences with other health personnel, and the perception that the communities have about the traditional and the Western-based ... system of medicine' (WHO,1985:4).

In order to test my hypothesis and its implications, I shall examine the results of a small-scale experimental project - the 'Tharaka Rural Health Care Project' (THARHCAP) in Kenya - which involved traditional healers, modern health care personnel (both expatriate and Kenyan) and the local community as a whole. Even

though the results of a particular case-study are always difficult to generalize, I do believe that the practical relevance of the project's results deserves careful consideration, either to replicate it later in other geographical areas or to expand it under a regional or national framework.

Moreover, at the theoretical level, I suggest that an analysis of the project outcomes can be a first, small contribution towards a more general comparative theory of medical professions, particularly in the African context. To achieve this, it is first necessary to reconsider the whole matter of the professional development of traditional medicine from a more theoretical point of view, since this problem is not only subject for discussion among administrators and physicians, but it raises some interesting anthropological issues as well.

0.2 Literature Review

A review of the relevant literature on our topic could start with Paul Bennel's remark that research work in the area of professionalisation in the African continent has been neglected by social scientists, especially in the medical domain (Bennel,1982). There are at least three important exceptions (5) to this generalized overview until very recently: one from the more general Sociology of the Professions and two from Medical Anthropology field.

The first one is Terence Johnson's paper on the development of professional occupations in former British colonies (Johnson,1973). His intention is to bring into question the

common view about 'professionalism' as a cultural universal: 'The view that the very practice of certain occupations necessarily gives rise to an elaborate culture which is unvarying whatever its social context' (1973:284). The reason is that neither such a view nor the theory of professionalisation from which it comes adequately accounts for the characteristics of the professional groups in Third World Countries. He suggests that such 'professions have undergone a process of historical development which differs fundamentally from that experienced by such occupations in the industrialized world' (1973:285). The differences are to be explained mainly by the particular social structures and power relations proper to the nature of colonialism: the relationship between professions and colonial administration took the form of 'corporate patronage', the reverse of professionalism. Whereas, in fact, professionalism and professionalization are means of controlling the producer-consumer relationship at the expense of the latter, in corporate patronage it is the client - the colonial state as a powerful corporate client - which regulates the professions, rather than the professionals themselves. Since in a number of colonial territories - including African countries - the system of corporate patronage of the professions emerged, the culture of professionalism with its ideology of independency and autonomy never developed: 'The government as the major consumer of professional services had the power to define its own needs and the manner in which they were to be catered for' (1973:289).

The situation did not substantially change after the end of the colonial era and the struggle for Independence: the new

states which inherited the colonial bureaucratic administrations retained the relationship of corporate patronage with the professions characteristic of colonialism. The absence of an actual middle class as a source of demand for professional services did not create the conditions for professional autonomy.

Apart from some oversimplifications in outlining the general characteristics of corporate patronage which he himself admits, Johnson's paper is perhaps the first attempt to question the way in which an ethnocentric view of the nature of the professions has been for a long time uncritically applied to Third World situations: stressing the very fact that the professions in such countries have no past of professionalism, he suggests that, as a result, their present and their future are likely to exhibit possible different forms of organization and practice.

Framed in a more anthropological context is the work of Allan Young analyzing the Ethiopian debtera as a 'quasi-professional' (Young,1975). The debtera is an ecclesiastic of the Ethiopian orthodox church who practises as a magician-healer using abinet magic,which includes some knowledge of an indigenous pharmacopoeia together with divinatory texts, prophylactic amulets, sorcery and techniques for ensuring the appearance and cooperation of demons. According to Young, whose analysis rests largely on Johnson's theory of professional power (Johnson,1967), the debteras can be considered as members of a quasi-profession because they own and monopolize a highly volatile resource - i.e. knowledge - while lacking any hierarchical structure or professional body:

'Recruitment to this quasi=profession means entering a market (abinet exchange) in which technical knowledge is the dominant medium of exchange, means of payment,way of storing wealth, and instrument for guaranteeing fair dealing'(Young, 1975:264).

Debtera's monopoly of knowledge - which includes both technical information and the secret of its sources - is possible because this market remains exclusive and closed to laymen. In a later work (Young,1982), Allan Young uses the case of the debtera to exemplify an analytical framework intended to describe different types of client-practitioner relationship: broadening Johnson's notion of patronage, he includes relations that are dominated by clients, who,though treated individually, can be seen as socially amorphous collectivities. Clients control the technical course of the debtera 's handling of the sickness episode in the sense that their expectations determine his choice of technologies (1982:34).

Rooted in a more practical problem is another medical - anthropological study by Dr Oyebola - a physiologist at the University of Ibadan - on professional associations , ethics and discipline among Yoruba traditional healers of Nigeria (Oyebola,1981). He shows that the existence of traditional healers' and herbalists'associations is not a new phenomenon: local associations existed among the Yoruba (at least) since 1886 (1981:90), even though they were confined to individual communities. Other associations on a regional basis were later formed, while efforts to make them coalesce into a single professional body at the national level have so far been unsuccessful. According to Oyebola,

'This proliferation of professional associations makes

> central control of the practice of traditional healers difficult and weakens their bargaining power with the government' (1981:92).

It is worthwhile to quote part of the interesting discussion which followed the publication of Oyebola's article (Bannerman et al.,1981). A crucial point is raised by Una Maclean when she states that,

> 'What has not yet been definitely established is whether the associations of herbalists that do exist have sprung up simply in response to recent competition from scientific medicine or whether at least a proportion of them are manifestations of the tendency of the urban Yoruba to join clubs which represent their occupational or social functions in the community' (in Bannermann et al.,1981:100).

Gilles Bibeau seems to answer this question when he suggests that Dr Oyebola has not stressed enough the rupture with tradition: these associations have multiplied, especially in African towns, since Independence - he argues - for two fundamental reasons:

> 'First, healers try to define themselves and their therapeutic activities within modern society, in proposing a new space to occupy; second, formal associations intend to force governments to make decisions regarding legal status of traditional medicine and individual licences for practice. Healers have obtained a new visibility in modern Africa, not only as individuals but above all as corporate bodies' (in Bannermann et al.,1981:94).

Moreover, professional codes of ethics have always existed among African healers: what is new is their concern to modernise former regulations without betraying their essence. The dramatic changes in the contextual setting of traditional practice requires, in fact, this process od adaptation.

Bibeau also disagrees with the position advocated by Dr Oyebola concerning the opportunity of constituting a national association of healers: according to his experience in Zaire,

Bibeau thinks that national associations cannot exist for the time being and that pluralism and coexistence of different local and regional associations must be stimulated to maintain democratic participation of individual healers. While he is not against federation, harmonisation and cooperation among associations, he feels that any effort, at this stage, must be preferably directed at developing strong local and regional associations:

> 'The national healers'associations I am aware of, in many African countries, appear to me as purely legal empty forms without any power of mobilization. Sociological characteristics of efficient healers' associations can be reduced everywhere to the two following traits: first, they are rooted in a geographical area, or in a particularly form of therapy (herbalists, ritual priest-healers, spiritualists ...); second, they are highly personalized, in the sense that leadership is assumed by a healer of great fame in this area. Only associations with these two characteristics have shown their capacity for 'bargaining power''(1981:94).

Only as a second step, will national-level associations slowly evolve from the incentive given to the formation of local associations.

According to Kris Heggenhougen, there are also other factors than mere size which influence the constitution of national general associations: 'For a variety of reasons, certain types of healers are more readily 'acceptable ' to ministries of health and cosmopolitan medical practitioners than others' (1981:99), and he quotes the case of traditional birth attendants as an example.

Heggenhougen also stresses the fact that the situation in Africa is somewhat different from , say, Asia where it might be more conducive to collaboration between traditional and modern

medicine : this is due to the existence of regional medical systems like the Unani, the Ayurvedic and the Chinese, with long established literate training, examination and professional associations governing their members. 'Great medical traditions' in the sense defined by Leslie (1976:2), are non-existent in Black Africa; and this is probably a disadvantage for any professional development.

One final remark is the one made by Gabriel Fosu, who argues that the ease with which new professionals will be accepted into the official health care system depends very much on the attitudes of physicians:

> 'They usually make the decision as to when and how to use the new professionals. Their decision is based on whether the services of the new professionals are perceived as role-elevating or role-threatening to them' (1981:96).

After these pioneering studies, the most important contribution to our issue came in the 1980s with the seminar of the International African Institute held at the University of Botswana in 1983 on 'The professionalization of African medicine': certainly a significant sign of the growing interest in the study of indigenous medicine as an emerging profession (Last and Chavunduka,1986). In his introduction to the papers presented, Murray Last points to the numerous ambiguities underlying the use of such terms as 'traditional medicine' or 'profession' as used by politicians, health practitioners, scholars and common people. In regard to traditional medicine, areas of ambiguities are in terms of policy, of divergent assumptions as to how and why traditional medicine works, and of stereotypes underlying the use of the term itself. Last suspects

that such ambiguities could be essential to the efficacy and survival of traditional medicine: yet, the problem becomes to what extent they are compatible with profession and professionalization. The answer, he guesses, is quite problematic: at one level, it is a matter of power, regarding ideological utilization and actual political processess; at another level it is about knowledge, and ways of structuring and transmitting it in the long-term.

As with traditional medicine, there are also ambiguities regarding the term 'profession' : historically, it referred to a select group of privileged occupations - the clergy, the lawyer and the doctor, primarily - which are the result of specific developments in Europe and America. Last puts forward a general hypothesis about the problem of the professionalisation of medical occupations in Africa: following Johnson, he argues that 'for most of the colonial period the medical profession as a profession scarcely existed in either anglophone or francophone Africa' (1986:9). It is only with decolonization that professionalization becomes part of a more general process of africanization of the former colonial administration: this 'secondary professionalization' was moulded on the lines of metropolitan professions and accompanied the establishment of a middle class whose social status was based on educational attainments. The attitude of the new medical class towards traditional medicine was initially one of suspicion, condemnation and competition or, at best, of ignorance. It is only in the late 1960s and 1970s, when the crisis in the ability of the medical

profession to meet the health needs of communities , especially in rural areas, became evident, that the incorporation of traditional healers into national health services as subordinates was seen as a new opportunity. Last argues that if the price for such recognition is a formal standardization and systematization of traditional medical knowledge, then it could not be a suitable option, given the peculiar characteristics of African Medicine. One alternative for healers' associations to escape such a trap - he suggests - 'is not to seek national status as a profession but rather to set up local schools limited to specializing in teaching and perfecting a specific technique (of bone-setting, for example) or in a specific field (like psychiatry)'(1986:12). It is undoubtedly a stimulating hypothesis, that leaves open the way to new different forms of professional development for African traditional medicine.

Some more recent developments in the Sociology of the professions (6) seem particularly significant for our topic. The work of Andrew Abbott(1988) is the more systematic and useful for our purposes; his central questions about the professions are: 'Why should there be occupational groups controlling the acquisition and application of various kinds of knowledge? Where and why did groups such as law and medicine achieve their power? Will professionalism spread throughout the occupational world?" (1988:1). To answer such questions, according to Abbott it is first of all necessary to get over the idea of 'professionalization' as a common process of development. Professionalization is, for Abbott, 'at best a misleading concept, for it involved more the forms than the contents of

professional life. It ignored who was doing what to whom and how, concentrating instead on association, licensure, ethical code. In fact, not only did it miss the contents of professional activity, but also the larger situation in which that activity occurs" (1988:1-2).

In the work of Wilensky (1964) and Caplow (1954), professionalization is seen as a sort of natural process with a regular sequence of events, a common pattern for all the professions (7): expert occupations evolve towards a particular structural and cultural form of occupational control. While the structural form consists of a series of organizations for associations, for control and for work developed in a certain order, the cultural aspect takes the form of legitimacy of this control obtained by attaching the expertise to general values like rationality, efficiency and scientific~~ness~~ validity.

According to Abbott,even the critics of professionalization, who reshaped the study of the professions during the 1960s and the 1970s - what he calls the 'monopoly school' (8) - never fully rejected the assumptions behind the concept of professionalization: the idea of a fixed series of events, the character of professionalism and its essential qualities. While continuing to see the same structural developments, the critics of professionalization attributed them not to a 'natural process' but to a desire for dominance: professions were corporate groups aimed at control of work . Despite this substantive difference with former theorists of professionalization, authors of both schools hold a surpringly consistent view of what professions are

and what about them must be explained. Abbott sees five basic assumptions hidden in the shared concept of professionalization:

> 'The first, is that change is unidirectional (...). Second, the evolution of individual professions does not explicitly depend on that of others (...).Third, the social structure and cultural claims of professions are more important than the work professions do (...). Fourth, professions are homogeneous units(...). Fifth, professionalization as a process does not change with time' (Abbott, 1988:17).

Rejecting all these assumptions, Abbott proposes an alternative theory that reverses the problematic assumptions of professionalization theories through a comparative and historical study of the professions in nineteenth and twentieth America, Britain, and France.

The central phenomenon of professional life is the link between a profession and its work, what Abbott calls 'jurisdiction': to analyse professional development means to see how this link is created in work, and how it is maintained by formal and informal social structure. By switching from a focus on the organizational aspects of professions to a focus on the division of expert labour among different occupational groups, it is possible to replace the problematic assumptions of professionalization theories. Furthermore, it is the interplay of jurisdictional links between professions that determines the history of individual professions themselves: thus the concept of jurisdiction leads directly to an analysis of the professions as existing in a system, since the histories of different professions are inevitably interdependent. Jurisdictional boundaries among them are, in fact, perpetually in dispute and the history of this disputes is, for Abbott , the determining history of the professions. Professions develop when

jurisdictions become vacant or are newly created; and if an already existing profession takes over a vacant jurisdiction, it may in turn vacate another of its former jurisdictions. This systemic model of jurisdictional vacancies shows how a set of historical stories can be analyzed without assuming a common career pattern, as in the concept of professionalization.

A second recent development in the Sociology of the professions regards medical professions in particular, and has taken place in Britain with the 'division of labour' approach: even though it represents still more a tendency in research and study than an established literature, it appears potentially one of the more exciting in its departure from traditional conceptualizations.

The focus of attention here is deliberately shifted away from professions as the units of analysis towards health care as a field of work. Health is considered an arena in which occupational identities are forged and statuses are established; and health work is done by workers seen both as skilled and unskilled, paid and unpaid (ill persons themselves, volunteers, family members, expecially women). The boundary of health work itself, therefore, shifts: the division of labour approach calls for re-conceptualization of available work. It seeks to broaden the discussion moving away from duly constituted occupations to deal with the totality of health work: 'What is and is not regarded at a particular time and in a particular setting as ill-health? What are the range of legitimate responses to this - and who then counts as a health worker? How are these health workers

regarded?' (Davies,1979:518).

Consequently, a comparative study of occupational roles in health care is not considered enough: we must turn to a comparative study of the total division of labour in health care if we are to appreciate the social nature of health work and to understand its variations between and within societies (Stacey,1977; Carpenter and Fairclough,1977).

Furthermore,occupational roles in health care vary over time and across societies: what are apparently the same roles - doctor, nurse, etc. - often differ considerably in various contexts. Health care roles are everywhere situated in an institutional matrix which defines contents, delimits their work, shapes aspirations and satisfactions. They are part of a more general societal division of labour, of a pattern of social relationship characteristic of the society in which they are embedded (9). The value of a comparative study of roles in health care, then, lies precisely in bringing this institutional matrix to our attention.

After reviewing the most relevant literature for our topic, I can now re-state my research problem as follows: is there in the work of the African healer anything like what Abbott terms 'jurisdiction'? And, if so, how can this concept be re-defined in more anthropological terms, given the different context from that of most industrialized societies for which it has been originally shaped? Besides, does this professional jurisdiction influence people's health-seeking behaviour in some way? And how? And finally, can the existence of such a jurisdiction be

considered a pivot for a real self-development process? And under what internal and external conditions?

0.3 Data collection

The thesis is subdivided into three main parts: Part I deals with information related to the structural and cultural context of Tharaka, providing an overview of the Tharaka experience of the management of illness, with an emphasis on health-seeking behaviour and the division of labour in health care from an historical perspective. Part II establishes the cultural boundaries of the healing jurisdiction of 'Ugao' and the cultural mechanisms used to gain the claimed control over it. Part III investigates the social dimensions involved in the development of that jurisdiction, by examining group formation among healers and the problems generated within the emerging profession. It also considers the matter of integration of Tharaka healers within the local health care system through an analysis of their interrelationship with the biomedical personnel and the health care facilities. Finally, it discusses the problem of legitimacy which the whole process of professional development raises both at the local and national level.

I wish to conclude by illustrating how and when the data for this work were collected and where they are exactly analyzed in the course of the thesis. The field-work conducted within the THARHCA Project (10) lasted on the whole twenty-nine months, subdivided into three different periods:

a- a preliminary survey (July - September 1984);

b- the proper project (July 1985 - June 1987);

c- a follow-up study (July - August 1992).

Different techniques of data collection were used at each stage. The preliminary survey was aimed at understanding the socio-economic and political context within which the study would be carried out. National health and other development policies were researched and their application observed at the micro level in Tharaka society. Tharaka perceptions and responses to the policies and strategies of the government and non-governmental organizations (NGOs) were also explored. Moreover, the relevant literature on traditional medicine in Kenya was fully examined (11). Data were collected through informal discussions and formal interviews with members of the community or of the foreign NGOs operating in Tharaka; and by submitting a questionnaire to thirty-four Tharaka Village Health Workers (VHWs). Information and material collected are partially used in Chapters One and Two.

During the second period, the bulk of the field-work was carried out. I particularly pursued three main ares of inquiry. Firstly, I tried to get a realistic picture of the Tharaka health care system, including both traditional and modern health care facilities. In order to study Tharaka medicine, I identified all the different types of traditional health practitioners (according to emic categories) working in the research area and I interviewed them. One hundred and three ethnographic interviews were conducted using an interview schedule and recording the answers with a tape-recorder (Cf. Appendix A). Most interviews

started off as normal conversations but leading questions were asked to elicit information about research issues. A few interviews were repeated twice when I felt that information had been withheld or intentionally distorted. Their contents are presented in Chapter Two.

To study the biomedical health care facilities, I conducted a survey together with the doctor-in-charge of Nkubu Hospital on all the facilities existing in the research area: one government health centre, two government and two Catholic dispensaries. Data were collected regarding their structure, personnel, services provided and actual problems: they are partially used in Chapter Two.

The second area of inquiry regarded the health-seeking behaviour of Tharaka patients. I followed a population-based approach, which provides a good opportunity to observe illness behaviour throughout a course of therapy and to differentiate actual individual and community patterns of behaviour. As it was naturally impossible to study the whole Tharaka population, the choice implied the selection of particular locations where I could either live or reach easily, so as to observe social situations and record the most interesting cases. Therefore I choose two areas with quite different characteristics in order to be able to make some comparisons between them: Kibuka and Kariekajeru. The two areas were selected on the basis of three main criteria: a) time of settling; b) transport and communication facilities; c) modern health care facilities.

In each area, a set of 25 households was selected and

followed up weekly for a period of about three months. Then ethnographic interviews were conducted using tape-recorder and a short schedule of questions regarding personal information about the sick, the perception of illness, therapeutic choices, decision-making during the health seeking process and final satisfation/dissatisfation with the practitioner. All the interviews were transcribed from the tape-recorder in Kitharaka and then translated into English with the translation crosschecked. Using this method, I recorded the thirty case histories I summarize in Appendix C and analyze in Chapter Three.

The third area of inquiry was focused mainly on the work of agao (Tharaka healers), their professional development and their interaction with biomedical personnel. This represented the main part of the field work during this second period. My apprenticeship with the agao was recorded both on tape-recorder and visually using a camera with slides: some fields notes were also taken. After each session, I then expanded my notes into a full account, using also the transcriptions done by my field assistant from the tape-recorder. The slides were a useful visual aid to recollect, some years later, my emotions and thoughts at first hand; and to analyze some details of the operational meaning of the symbols used by the agao. Both the ethnographic material and its analysis form the backbone of Part II (Chapters Four, Five, Six and Seven).

The professional development of Tharaka agao were then followed by attending regularly their fortnightly meetings,

keeping records of people's behaviour and of the agenda discussed; I also attended the collective oath each group made following the traditional ritual with the goat (giciaro). After my departure, I continued to receive reports along with the minutes of each meeting made by my field assistant. All these data are discussed in Chapter Eight.

Furthermore, the interaction of Tharaka healers with biomedical personnel and facilities involved a substantial number of meetings with CUAMM doctors and local nurses, either in the bush or at Tharaka dispensaries and Nkubu Hospital. I recorded each one, writing up reports of the discussions. The work with biomedical and indigenous practioners to set up a cooperation and referral system was based on the comparison of sixteen therapeutic rituals and five clinical cases. The sixteen therapeutic rituals by agao were observed and recorded; a comparison was made of the treatment of the same sickness as practised by different agao in different areas of Tharaka. After the treatment was recorded, an ethnographic interview was conducted with each of the sixteen agao using a check-list related to the main items of their treatments: acts, formulas, songs, speeches, actions, instruments used as well as explanations regarding the etiology, diagnosis and classification of the sickness treated. Then, I collected case histories of the five patients whom the doctors followed together with agao: I observed the treatment performed by the agao and by the physicians and filled in five medical-anthropological comparative charts (Cf. Appendix D), including also clinical data (done by doctors themselves). All the above material is discussed in

Chapter Nine together with the results of the numerous meetings and seminars held with CUAMM doctors and other biomedical personnel.

The interaction of agao's groups with the local community and the Kenyan government is another important step of their professional development: public meetings with local authorities and village people were held on many occasions. They are described in Chapter Ten in the context of the agao's struggle for legal recognition.

Finally, the follow-up study conducted during the third period of stay was mainly aimed at initially evaluating the performance and sustainability of the project after five years of time. By a series of semi-structured interviews and informal conversations with key informants, and of meetings and focus groups with the agao groups and biomedical personnel, I was able to recollect the history of the project during this five years of my absence, assessing weaknesses and strengths of the project. The results are discussed throughout Part Three (Chapter Eight, Nine and Ten). In the Conclusion, I try to outline and to analyze the results synthetically, discussing their more general meaning both for a comparative theory on medical professions and for a more applied perspective on the issue of development of African indigenous medicine in the near future.

FOOTNOTES TO INTRODUCTION

1) For the rhetorical meaning the expression has assumed in the last years, see the Introduction of Murray Last in Last and Chavunduka,1986:1-19,also discussed below; here the expression is used to denote the complex of indigenous medical traditions of the African continent, without any archaic implication.

2) A later definition of 'African traditional medicine' as a distillation of African culture is that of Mamadou Koumare as 'the total body of knowledge, techniques, for the preparation and use of substances, measures and practices in use, whether explicable or not, that are based on the sociocultural and religious bedrock of African communities, are founded on personal experience handed down from generation to generation, either verbally or in writing, and are used for the diagnosis, prevention or elimination of imbalances in physical, mental or social well-being' (Koumare',M. 'Traditional Medicine and Psychiatry in Africa' in Bannermann et alii,1983:25).

3) The literature on TBAs is, at present, enormous: for a useful annotated bibliography, see WHO,1985a; a field guide to their training, evaluation and articulation with health services is WHO,1979.

4) The concept of 'oriented social change' is considered as describing the result of a 'planned cultural contact' situation in Bastide's terms (1971): the whole issue is discussed in Chapter Eight and in the Conclusion.

5) A few other exceptions, not considered here, are the works on the 'emerging physician' in Zaire (Craemer and Fox, 1968) and on the legal professions in Southern Nigeria (Adewoye,1968) and in Ghana (Dias,1981).

6) Sociological interest in the professions is usually dated back to Carr-Saunders and Wilson (1933) in Britain, and to Parsons (1951) and Everett Hughes (1958) in USA.

7) Even though the chain of events (first professional association, first governmentally sponsored licensing legislation, first professional exminations, first ethics code, first professional school,etc.) is not exactly the same among different theorists of professionalization, it is the concept of a regular sequence of steps that matters here.

8) Abbott subdivides different sociological theories of the professions into four basic categories, according to their substantive version of professionalization: the functional version (Carr-Saunders, Wilson, Marshall, Parsons) considers the professions as a means to control the asymmetric expert-client relationship ; in the structuralist scholars (Millerson, Wilensky, Caplow), professions are merely a form of occupational control, and professionalization becomes an

explanation of why they displayed their structural properties; the monopoly school (Larson, Freidson, Johnson, Berlant) considers professions as corporate groups aimed at social mobility: professionalization here is the result of external social processes (like the rise of bureaucracy); finally, the cultural version (Bledstein, Haskell) emphasizes the cultural authority of the professions and the cultural legitimation as a central process in professionalization.

9) Classic approaches to social division of labour are Marx (1859), Durkheim (1893), and Weber (1947).

10) For a full account of the methodology used in the Project and some remarks on its implications for the researcher's role, see Appendix M.

11) Research on indigenous medicine carried out in Kenya includes, during the colonial period, a number of anthropological studies usually done by European anthropologists (Wagner, 1939 and 1970; Levine, 1966), apart from Kenyatta (1938), under the headings of religion, magic or witchcraft. After Independence, indigenous medicine began being considered as an autonomous field of study : new research focused on factors affecting the utilization of traditional medicine in the presence of biomedical services (Thomas, 1970; Good,1980; 1987); on the potential contribution of indigenous healers to health development (Kimani,1980, Kimani and Nyamwaya, 1981); on intracultural variation in societal responses to illness (Nyamwaya,1983); on the impact of colonial rule on health development (Mburu,1981; 1992); on maternal and child health (Van Ginneken and Muller,1984).

Plate 1. During the population-based survey: in front of my hut together with its owner, the Sub-chief of Kamanyaki (May 1986).

Plate 2. The old muringia Gauki during a divinatory session (June 1986)

PART I

THE CONTEXT

CH.1 THE THARAKA SETTING

a) Early Settlement between History and Myth

The Tharaka, who numbered about 60.000 in the 1979 Kenya Population Census (Republic of Kenya, 1981), live in Meru District of the Eastern Province of Kenya (1). According to the most recent ethnolinguisitc classification (Sutton,1974:82), they are part of the Highland Bantu linguistic group; Murdock (1959:342-3) had included them - using a more geographical criterion - in the Kenya Highland Bantu along with the Meru, Chuka, Embu, Mbeere and Mwimbi.

The issue of classification has been a controversial matter in the published literature on the Tharaka: while the reports of the early explorers and administrators (Gedge,1892; Hobley,1910; Champion,1912; Dundas,1913 and 1915; Lindblom,1914) treated the Tharaka as though they were a separate 'tribe', later British administrators (Lambert,1956) and Italian scholars (Bernardi,1959; Volpini,1978) included them in the larger Meru ethnic group together with the other eight Meru sub-tribes of Tigania, Igembe, Imenti, Igoji, Miutini, Mwimbi, Muthambi and Chuka. Most recently, two American scholars, the anthropologist Lowenthal (1971 and 1973) and the historian Fadiman (1982), indicate that the earliest descriptions could have been more correct than the label 'Meru' attached by colonial officials to all the people living in Meru Native Reserve; they suggest that Tharaka may as profitably be said to be related to Embu or Mbeere, as to Meru (Lowenthal,1971:1). Finally, the last three

Kenya Population Censuses (1969,1979,1989) have listed Tharaka as a separate tribal entity.

The conflicting views bring up the overall problem of ethnicity ("What is a tribe?') which is not my intention to tackle here; what seems to me particularly significant is both the absence of a clear archaelogical or historical evidence and the inadequacy of linguistic data to confirm either classification. In fact, while written sources are absent until the early colonial period, oral sources are even more controversial. Tharaka people share with the other Meru groups (except the Chuka) an elaborate set of myths in their oral tradition regarding an exodus from an original homeland called Mbwa near a large body of water, where they were slaves to 'fair-skinned people', but succeeded in escaping and crossed a wide stretch of water which divided miraculously to allow their crossing (Bernardi,1959:57; Volpini,1978:276; Lambert,1950:7; Fadiman,1970 a-b;1973 a-b). They appear to have migrated along a river to the lowlands of their present home, where they met with the aborigines living there, Njiuwe and Gumba (2).

Apart from the manifest analogies with the biblical exodus which can leave one in doubt about the genuineness of this myth of migration (3), there is considerable disagreement as to routes and dates of migration. Most authors identified the 'large body of water' with the Indian Ocean, the 'fair-skinned people' with the Arabs and the river with Tana river:this is to say, that Tharaka came from the East Coast of Kenya (Lambert,1950:7; Fadiman, 1973 a :17). Lambert dates this between the fourteenth and the eighteenth centuries, while other scholars believe the

migration took place earlier (Fleming,1965). Among the oral traditions of the other Kenya Highland Bantu only the Kamba share a similar myth of exodus (but not from the coast), according to research carried out among them (Munro,1967:25). A scholar who has studied the Kikuyu people argues that ancestors of the Tharaka, Kikuyu, Embu, Mbeere and Meru cluster formed a unique group of proto-Bantu called 'Thagichu' who migrated to the present-day region of settlement from Tigania and Igembe before the fifteenth century (Muriuki,1974:49-52); he quotes linguistic and archaelogical evidence in support of this opinion.

Without a more detailed analysis, the only conclusion we may draw, as does Bernard (1972:34), is that the Tharaka and other Meru groups probably arrived at their present area of settlement no later than 1700 to 1750.

b) Environment and Technology

The physical setting of Tharaka land is quite different from the other parts of the Meru District: in fact, it is necessary to distinguish between highland and lowland Meru. The highest parts of the district extend along the eastern slopes of Mt.Kenya, at an altitude between 1200 and 2000 metres above sea level; they are well watered and verdant. To the south-east of the district the land falls to 600 metres above sea level, and forms a drier and reddish, hilly landscape. While the highland people include the Igembe, Tigania, Imenti, Miutini, Igoji, Mwimbi, Muthambi and Chuka, the lowland people are mainly

Tharaka, plus a few sections from these other groups (Map 2). Although there are some rivers which are fed by snow from far up Mount Kenya and cross through Tharaka land to enter the Tana river, (for example, the Thingithu, Kathita and Mutonga), the traditional subsistence mode of the people is totally dependent upon seasonal rainfall. There are two annual periods of rainfall: kiatho (October-December) and nthano (March-May). When there has been too little rainfall, drought and starvation have long been common occurences in Tharaka, as the accounts of the early travellers and colonial administrators like Tate (1904:228) demonstrate. Indeed, I can agree with Bernard when he states that '...the eastern lowland people were hampered by fluctuation in the environment to a far greater degree then their highland brethren' (1972:66-7). What he calls the 'lowland system'is - in a cultural-ecological framework - the result of a 'negotiation' evolved over generations between traditional technology and economy on one side and the harsh living conditions of the hot and dry Tharaka environment on the other. Probably, an essential part of this 'negotiation' was that the population remained small due to a high death rate, and that it remained dispersed over a large area (population density was 34 persons/sq/km. over an area of 1,496 sq/Km, cf. Republic of Kenya, 1989).

A fundamental aspect of the adjusting to the environmental variables was the system of shifting cultivation adopted by Tharaka agriculture: each polygynous family cultivated several small scattered fields which belonged to different wives for no more than five-seven dry seasons, at which point the fields were allowed to revert to fallow for a long period (10-20 years),

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during which time the bush was potentially able to recover. According to Bernard 'the very nature of this activity required eventually that the homestead itself as well as the fields be shifted' (1972:75), in order to keep the sparse lowland population in reasonable balance with the environment.

Another important feature was the choice of food crops drought-resistant enough to survive a large seasonal water deficit, especially millet, sorghum, and local pulses (nchugu and nthuruku), which provided the bulk of Tharaka diet. Animal husbandry and subsidiary activities provided the remaining part of the diet, helping to offset the deficiencies in the staple foodstuffs. Livestock included East African cattle, goats, sheep and smaller domesticated animals such as chicken. Yet animal husbandry was mainly done for its important social significance. Cattle were a measure of individual and family wealth; goats and chickens were mostly used for ritual functions (witchcraft, oaths,etc.) and for social obligations (payments or fines, in resolving disputes); all were used for bridewealth. Nevertheless, 'ceremonies and ritual occasions did provide ample opportunity for meat consumption, especially of sheep and goats' by everybody (Bernard,1972:72).

The specialized knowledge Tharaka men possessed about the habits of wild animals made them excellent hunters of elephants, rhinoceros and smaller game like antelope and deer; even their bee-keeping was based on a detailed understanding of bees'habits.

Although the cultural-ecological highland/lowland

dichotomy can explain most of the peculiarities of the Tharaka mode of interaction with the external environment, there is undoubtedly a cultural heritage they have in common with the other Meru subgroups: this includes forms of the division of labour, technology and settlement patterns. Generally speaking, it can be said that agriculture was a matter for women whereas animal husbandry was men's concern. Yet, Tharaka men participated in cultivation (especially in the heavy work of clearing) and the division of labour was rather more complex. Agricultural techniques include burning as an initial step in the preparation of fields for cultivation, while a simple but functional technology included the digging stick (murua) and a variety of different types of knives. Finally, the Tharaka settlement pattern was one of dispersed extended-family homesteads, usually located on hillsides for better defence.

c) Social Organization

All scholars agree that Tharaka traditional social organization was based on two main institutions: the clan system and the age-set system.

According to Bernardi (1959:10), the Tharaka clans numbered thirty-one; Lowenthal counted thirty-two (1973:29), while Volpini collected a list of twenty-nine (1978:256-263). The Tharaka word for clan is mwiriga (pl. miiriga), which represents the largest unit of kinship and is composed of all the male descendants of a mythical ancestor. Traditionally, ownership of the land and of the livestock was vested in the the clan which

also constituted a residential unit. Each clan is usually subdivided into a few lineages called iriko (pl. mariko) which include all the descendants of a common, well-known ancestor (patrilineage). The smallest unit of kinship is the mucii, the household, which usually includes three generations and their families. The term mucii is also used to indicate the conjugal family and its homestead. Since the mucii is ego-defined by Tharaka people, as Lowenthal states, it does not refer to a systematic unit within the clanship system:

> 'While technically it could be stated that a mwiriga or a riko is made up of a collection of mucii, this would not be an accurate reflection of the situation, because for every individual (with the exception of direct siblings who share a single mucii) there would be a different mucii' (Lowenthal,1973:33).

All the various units of the Tharaka clanship system (mwiriga, iriko, mucii) could link in with the others (even if not at the same level), producing a social network of interrelationship. The usual form of such a relationship was called giciaro. Bernardi translate it as 'blood brotherhood' (1959:16), while Lowenthal points out three major types of giciaro according to the method whereby they were formed (1973:36-48): he stresses the fact that each type implied a different set of mutual obligations and exogamic restrictions - giciaro defined by kinship (the strongest), by oath (a less strong form) and by goat (the weakest).

The usual exogamous unit is the clan, even though it is not always so well defined (Middleton and Kershaw,1965:39): nobody may marry a member of his/her mwiriga. Marriage implies a long series of rights and obligations on both sides, and a bride-

price traditionally paid in cows,goats, honey, hydromel and other items; and it is virilocal.

The other main social institution was the age-set system. The sets were formed through circumcision for men and clitoridectomy for women. According to Lowenthal, there was an important distinction between the way Tharaka and other Meru groups define age-sets: while the kiMeru word for age-set is nthuke, the same word in kiTharaka does not refer to an age-set, which is named itana:

> 'An age set (itana) is a social category composed of individuals with a single common attribute: the time of their circumcision, and it includes all persons in Tharaka circumcised at the same season and in the same year... An nthuke,on the other hand,is a group of individuals belonging to one or several matana, members of the same grade who are dining together. Nthuke is basically a group which lacks permanent definition as to membership since one's nthuke is the collection of approximate age-mates with whom one is at any particular time' (Lowenthal,1973:91).

In Tharaka the set-naming procedure was linear;the period between the formation of age-sets ranged from four to seven years.There were four age-grades structured by three 'rites de passage': the aiji nkala (not a true age-grade but a unit including all pre-initiation boys), who became aiji rugo through kirimu ritual ; then passing through nthano (circumcision) they became nthaka (warriors); finally, by the ritual of the kiama gia nkomango, they became akuru ba kiama (elders of the council). The age of males at the time of circumcision prior to European contact was said to be between 18 and 25 years old. After that they entered the garu, the warriors' house where they remained even after marriage until they were considered ready to become elders; this was defined as when one member of the itana had a

daughter old enough to go singing with warriors, just prior to the girls' own initiation. For women the time for clitoridectomy was after their first menses: there was no special age-set for them and they were included in the age-set of men circumcised in the same year. The importance of age-sets for women was purely ritual, since they would have virtually no practical affiliation with their set.

Circumcision took place in one of the two dry seasons: thano (the dry season of June-September) was the circumcision period for men, while muratho (the dry season of December-February) was usually the period of female circumcision.

d) Political and Jural System

Traditionally the Tharaka were a 'tribe without rulers' (Middleton and Tait,1958; Fortes and Evans-Pritchard, 1940) as were the other Kenya Highland Bantu; this disappointed the first colonial officers like Dundas who wrote:

> 'I feel convinced that these tribes had no heads or leaders who could be dignified with the name of chief... The conception of a chief as a functionary essential to the welfare of the tribe had not become familiar to the people, and therefore the office of such an authority formed no part of the tribal organization' (Dundas,1915:238).

The political system of Tharaka was egalitarian and based on the segmentary nature of the clanship system. Within each clan political authority was exercised by the elders through their councils (biama bia akuru) at two distinct levels: the council of the lineage (kiama gia iriku) and the council of the

clan (kiama gia mwiriga). Such councils were not well-defined bodies but were formed according to context: if the decision to be taken involved only members of the same lineage, e.g., that was a matter for the kiama gia iriku. In the case of major decisions - such as whether or not to conduct warfare - the council of all the elders of the tribe (kiama gia Tharaka bonthe) was the decision-making body. All elders of the different biama (councils) had the right to speak and decisions had to be taken by a clear consensus on the basis of reasoned arguments; a particular role was played by the agambi (speakers) , elders who were recognized as very good at speaking.

According to Lowenthal (1973:49), the Tharaka traditional political system differed from other Meru tribes in that the age-set system had little political activity associated with it; whereas for other groups like Tigania political power was held by each age-set serially for about fifteen years (Mahner,1970; Lambert,1956), there was no single ruling age-set in which power was vested :

> 'Among the Tharaka all elders, regardless of set, are involved in the decision-making process, and there do not appear to have been grades of elderhood'(Lowenthal,1973:103).

The only political function of the age-set organization was, for this author, membership of the akuru ba kiama, the final age-grade of the system: all who were members of this age-grade were considered elders and, as such, rulers (4). Since political decisions were mostly decisions involving lineages and clans rather than age-sets, the Tharaka political system was characterized by clanship system and not by the age-set system.

The same could be said of jural matters, which were not obviously separated from political affairs. For local quarrels, arbitration by a mugambi was requested: apart from his ability as an orator, this elder was selected for this informal office because of his apparent wisdom,honesty and impartiality. Each clan had its own agambi and in case of a dispute between members of different clans, an ad hoc kiama gia akuru was formed, composed of agambi from the different parties involved plus some others from totally disinterested clans.

The mediatory character of such biama is demonstrated by Dundas, who considers them 'rather as a court of arbitration than a court of decision' (1915:260): their main purpose was to settle the cases on the invitation of both parties in accordance with recognized customs to prevent strife between creditors and debtors and a resort to open hostilities. In this light, it can well be understood,

> 'the curious custom of speaking through a proxy. A, a plaintiff, will address his remarks and refutations to B, who has nothing to do with the case, and C will address D; but both A and C address B and D by the names of A and C respectively.The Theraka are remarkable for their hot temper, and it is more than likely that if the parties addressed each other they would be unable to restrain themselves, and therefore this roundabout method is used' (Dundas,1915:250).

In consequence, arbitration by the councils often resulted for the claiment in compensation which implied more than the mere payment for an injury: it carried also the idea of a sort of purification from the bad effects of the crime, which could only be wiped out by compensation.

Dundas reports a series of very interesting schedules of compensation for different kinds of offences (1915:281): from

homicide to hurts, from sexual offences to theft, from witchcraft to divorce, the compensation was traditionally paid in the form of a certain number of goats; only in the case of a recidivist killer would his execution be ordered by a particular council called kiama qia mbiti (council of hyenas). In such cases, it was carried out by members of the accused person's clan, so that no penalty could be assessed against the executor (Lowenthal,1973:59; Volpini,1978).

e) Religious beliefs and specialists

As in other African cultures (Mbiti,1969), every facet of Tharaka life acquired not only temporal but also supernatural significance. To understand fully the traditional social and political organization of Tharaka one must therefore examine not only its secular structure, but also the supernatural sphere related to it.

Religious beliefs were based on a hierarchy of three different levels: God, the ancestors and the spirits. The most powerful was Murungu (God), considered as a distant entity living either in the skies or atop the peak of Kirinyaga (5). Although he was described as Creator, there is no cosmogony in Tharaka oral tradition; his relationship was with the entire people, and thus beyond the influence of individuals. Acting as intermediaries liaising between the Creator and mankind were the nkoma cia bajuju (ancestors, literally 'spirits of the grandparents'), those who had departed from the community at a

ripe old age. They were considered the patrons of the mucii and of the mwiriga, since they had once been part of the family, they knew the needs of people and were in a position to intercede on behalf of the living. They were generally believed to be benevolent, peaceful and living a happy life in the supernatural world.

Conversely, there was a category of spirits called nkoma who were considered to be evil and hostile towards the living: they were believed to be those dead human beings who during their life time had been either morally wicked or had died unmarried or childless, and thus had not been socially incorporated into the community through the household.

Geographically, while the ancestors lived in the shade of Murungu, nkoma lived in the woods, hills, lakes and rivers. They roamed about singing, in the night, and lived a very unhappy after-life (they were thought to be malicious, jealous and mischievous); this made them disturb the peace and harmony of the living. Their hostile attitude towards the living made them responsible for many misfortunes experienced by the living, such as illness and death. However, they could even be sent by God or by the ancestors when either became angry because people had failed in their duties towards them. The relationship between the living and these spiritual beings was to be mantained by periodic rituals, which took the form of prayers, sacrifices and offerings. Ritual practices were presided over by elders who had terminated their marital relationship: there were no particular priests. Public sacrifices were offered to Murungu when particular calamities such as famine, epidemic and prolonged

drought threatened the community's existence. In everyday life offerings were made to the ancestors by the elders of the family as a gesture of cordiality, and to the spirits as a bribe to appease them whenever they seemed to be extremely hostile towards the living.

Apart from that of the elders, a religious role was played by some specialists like the mugao (healer), the kiroria (prophet) and the muringia (diviner): each of them will be examined in the next chapters because of the medical aspects of their work. The only office of religious relevance which Tharaka had (in common with most of other Meru tribes) was the office of Mugwe made famous by Bernardi's first research work (1959) and by Needham's analytical note (1960). He was a sort of religious dignitary, invested by Murungu with a particular power to protect and bless his people. The main symbol of this power was the kiraqu, a coiled piece of copper or brass wire which he put on his left hand and which remained hidden under his mantle. The office of the Mugwe was hereditary: among the Tharaka he was always chosen from the clan Kithuri and from a specific lineage, Kirura, in that clan.

According to the literature, it seems that,

> 'the Tharaka are the only group for whom the office is jurally inherited by primogeniture and, barring complete incompetence, the next Mugwe would be the eldest son of the previous Mugwe' (Lowenthal,1973:61).

This would imply that the office of Mugwe was probably somewhat different in each of the Meru sub-tribes. There has already been a considerable amount of discussion about the real political power of the Mugwe: here it is only possible to report

Needham's dualist interpretation that associates Mugwe with leftness - and, as such, with religious power - as opposed to the elders associated with rightness, meaning political power. To what extent such symbolism is really consistent with Tharaka culture will probably remain an open question: undoubtedly, the Mugwe exercised also a certain political power. If warfare was to be conducted, then the Mugwe's blessing was necessary to ensure its success: and his ritual power could also influence political decisions taken by the kiama gia akuru on whether or not to go to war. But the Mugwe was, after all, himself an elder and this fact seems to contradict the suggestion of a real system of dual oppositions like that suggested by Needham. The last Tharaka Mugwe, M'Rwanda, died in the late 1960s (Volpini,1977): after him, nobody else was elected. It was a sign that things were changing (Bernardi, 1959:170).

f) Internal and External Dynamics: the Social Change

The above is an outline of the Tharaka 'traditional' social, political, economic and religious system. However, since the present day situation is rather different, I have now to tackle the problem of social change - that is, I have finally to identify the specific dynamics which have produced particular 'movements' in the system itself and in its interrelationship with the external environment.

The first kind of such dynamics are the internal ones, which originate from lack of balance, tensions and conflicts

intrinsic to the system itself (Balandier,1971). The movements of the njuri represents an interesting example of such an internal dynamic: the continued conflict within the Tharaka age-set system between the nthaka (warriors) and the akuru ba kiama (elders) gave rise in the nineteenth century to the kiama gia njuri, whose purpose was mainly political and jural power (Volpini,1978:185-189). Until then, the biama bia akuru (councils of elders) had been the only empowered political bodies: the nthaka were completely excluded, although the oldest unit of them was aged between 30 and 50. The kiama gia njuri joined together the nthaka of the garu with the akuru ba kiama, simplifing the age-set system itself and finally allowing the nthaka to take part in political affairs. Another important characteristic of the njuri was their inter-tribal nature: they usually met in the Tigania area, drawing people from all Meru sub-tribes, with the purpose of settling any inter-ethnic dispute and unifying all Meru people.

A second kind of dynamic relates to the external factors: in the case of the Tharaka, as for most African communities, they undoubtedly played a chief role as a source of change in the last century. Although it is clear that,

> 'far from the usual image of isolation, stagnation and lack of economic interaction, pre-European Meru was characterized by lively trade in some items and even market places in certain areas' (Bernard,1972:44),

the coming of the Europeans produced a long-term, deeply-rooted social change. But we have to distinguish two main periods.

The first period starts during the last two decades of the nineteenth century, when the first European explorers travelling through the region had to fight with the Tharaka

(Peters,1891; Chanler, 1896; Neumannn, 1898). Because of their reputation for being a brave and warlike people, travellers avoided passing through their country and for a long time Tharaka land remained a closed, 'uncivilized' territory:

> 'Yet the Atharaka are treated with the greatest circumspection, and no traders, not even coloured ones, are admitted to their country. Being very primitive by nature, too, they have been preserved by these measures in their original state, and are one of the tribes of the protectorate as yet most unaffected by civilization' (Lindblom,1914:3).

When 'civilization' arrived in Meru in 1908 with E.B.Horne, who established the first colonial station and later became the first D.C., Tharaka proved to be the only recalcitrant group:

> 'The greatest amount of opposition, however, was from the Tharaka; isolated in their hills, at a considerable distance from any authority, they remained obstinately hostile and suspicious for a considerable time. On several occasions they made unprovoked attacks on Government officials, but the opening up of the sections round them served to break down their prejudices; a determined official attitude soon persuaded them to accept the position of affairs' (Ordwe-Browne,1925:36).

The 'determined official attitude' was shown in 1909 when Tharaka warriors killed several soldiers on two separate occasions, bringing about a brief but brutal punitive expedition by the King's African Rifles (Moyse-Bartlett,1956:206). This marks the beginning of the early colonial period in Tharaka, which continued until World War II, during which we can see very little concrete evidence of social change; apart from the opening of some shops in the native market of Chakariga, Tharaka life continued to be unaffected, on its eastern lowlands, by the forces of British colonialism.

The first ethnographic accounts - written by C. Dundas

(1915) and A. Champion (1912), both assistant district commissioners in Kitui District in 1911, who briefly visited the country on tour - testify to the existence of a relatively prosperous subsistence economy:

> 'It had generally been supposed that the Tharaka were a poor people, but after spending many days walking about among them I am convinced that this is not the case. Though the herds of cattle are not so large as those of the Akamba, nevertheless every man of any standing possesses from ten to a dozen head. Goats, honey barrels, and tobacco are possessed by everybody' (Champion, 1912:69).

Even from the political standpoint, the introduction of local chiefs for administrative purposes (tax collection,etc.), the attempt to use some members of the kiama gia akuru as local Native Tribunals and furthermore the repression of the kiama gia njuri, proved to be a failure. The 'obstructive action' of the njuri was considered by the colonial officers the main reason for failure (Meru District Commissioner,n.d.): they considered the kiama gia njuri a secret society connected with witchcraft.

Things radically changed after World War II, when the forces of modernization spread throughout Tharaka and Meru as well, producing substantial behavioural and structural changes. This second period begins with a belated recognition of the kiama gia njuri as a means of indirect rule by an enlightened colonial officer (Lambert,1947). The Mau Mau liberation movement was already growing and the Tharaka njuri took an active part in it together with other Meru people. When the independence came in 1963, the introduction of the new national political system radically modified the indigenous political structure, practically depriving the kiama gia njuri of any formal

authority. Local native officers (chiefs and subchiefs) took over the authority of the kiama, even though they continued to need the support of the akuru ba kiama of the different miriga for their work.

Other important structural changes took place in the economic sphere and in settlement patterns. Although the transportation network and the system of markets remained concentrated in highland Meru, they started affecting even the lowland subsistence economy. Fundamental elements of transformation were the introduction of cash-crops like cotton and of new staple crops like maize, which influenced patterns of cultivation and economic behaviour, and also altered the traditional diet. But the two most important structural changes were land reform and resettlement. Land consolidation in 1966 introduced individual land ownership in the traditional system, disrupting clan ownership. Furthermore, settlement schemes accentuated, during the sixties and the seventies, the dispersion of clans over the landscape, a trend which had already started started in the emergency period (1952-56) as a way of escaping colonial control. Tharaka began to move up-slope, towards the Chuka, Mwimbi and Imenti areas (Map 4). Boundary disputes and conflicts among the settlers are still one of the main sources of controversy for local officers and the courts (6).

The political and economic events which took place after World War II inevitably affected also the social organization of Tharaka: missionaries were particularly active at this local level as agents of change. The three major missions

established in Meru District between 1911 and 1922 - first the Italian Roman Catholic at Mujwa (South Imenti) in 1911, then the English Methodists at Kaaga (North Imenti) in 1913 and Maua (Igembe) in 1928 and finally the Scottish Presbyterians at Chogoria (Mwimbi) in 1922 - began their penetration in Tharaka after World War II, bringing schools, dispensaries and even an experimental farm. Their long-term proselytism deeply affected traditional social institutions like circumcision and polygamy. The rituals surrounding circumcision have been dropped and today some wealthier families have their sons circumcised in a hospital rather than in the bush. The age-set system as a whole has changed and been simplified: the gaining of the status of elder, for example, is not linked any longer with membership in a particular age-set, but is simply the consequence of having a child circumcised. Moreover,the age at circumcision is much lower, even 10-12 years old, and the ritual has become simply a sign that someone is a mutharaka (a Tharaka person). Even polygamous families are increasingly rare among Christian Tharaka due to their religious beliefs.

The growing demand for education also drove the new independent Government to build up a wide network of primary schools and even a secondary school at Gatunga (North Tharaka) although the general state of the school is actually very poor.

I will end this summary of background data on Tharaka with some more general considerations about the issue of development. As has been mentioned, Tharaka people experienced, during the last forty years or so, a strong 'wind' of modernization, due to

the convergent actions of different external agencies of change (colonial and independent governments, churches, a trading economy, etc.): this in turn has meant the disintegration of many aspects of Tharaka traditional culture (the biama, the Mugwe, religious beliefs, subsistence economy, the age-set system, clan-based property,etc.). To what extent have all these traditional items been replaced by new modern elements? Tharaka is nowadays generally considered the poorest area of Meru District with practically no serious economic development, and is increasingly affected by such new social phenomena as drunkenness, juvenile delinquency, unemployment, prostitution, etc. The other Meru groups are generally better off economically than the Tharaka and this has deepened the old highland/lowland dichotomy in Meru, creating an economic and social rift as well as a technological gap.

When Prof. David Brokensha undertook a brief survey in the early seventies in order to make suggestions to the Kenya Government concerning development in this area, he stressed the good prospects for irrigation, given the several permanent rivers in the area (Brokensha,1971). The very fact that this potential has never been actualized is undoubtedly the main reason for the serious recurrent drought in the area. If one would inquire the reason why the lack of development, maybe one could ask the same question two scholars have recently suggested for Kenya as a whole:

> 'Have the Kenya lowlands not become colonies of the upland core of the busy capitalist economy?' (Wisner and Mbithi,1974:356).

FOOTNOTES TO CHAPTER 1

* In this chapter, I preferred to use the past tense when the cultural items under discussion have disappeared, at least in the traditional form; conversely, the use of the present tense means that it is still a living item of Tharaka present culture.

1) A small number of them live in Thagichu area, beyond Tana river, in Kitui District.

2) There is a description of these Njuwe proto-inhabitants in Shackleton (1930:201); while for the Gumba, see Kenyatta (1938:23) and Lambert (1950:45).

3) Bernardi (1982:105) states that the myth of exodus is a frequent cultural item, used as justification for ethnic migrations, in Africa and Middle East cultures.

4) Kenyatta (1938) reports a similar situation for the Kikuyu: once elderhood is reached, the exact age-set into which one was circumcised is less important for political purposes than is council membership.

5) Kirinyaga (or Kirimara) is the local name of Mount Kenya, common to all Highland Bantu: it is composed of kiri(mountain) and nyaga (shining).

6) Even during the period of my fieldwork there was a serious incident of national relevance. In October 1986, during a meeting being addressed by the D.C. of Meru to resolve a long-term border dispute between the people of North Imenti and Tharaka, a group of naked Tharaka youths emerged from the bush, singing traditional war songs and raising their bows and arrows: two people were shot dead and several others were injured,one of whom died later. As a Kenya magazine wrote on the episode:

'Although land disputes have often proved sensitive in Kenya, the Meru incident was the first where those opposed to a settlement have attacked a meeting being chaired by a DC.' (The Weekly Review, Nairobi, October 24,1986, 'Meru Mourns Dead after Thugs Attack', Nairobi).

CH. 2 THARAKA DIVISION OF LABOUR IN HEALTH CARE: AN HISTORICAL PERSPECTIVE

2.1 Medical Domain and Division of Labour

After having considered the general setting, if we now turn to deal specifically with the medical aspects of Tharaka culture, we are immediately faced by a problem: how to properly identify such medical aspects? How to establish sharp boundaries for the medical domain? As in many other African cultures, Western medical concepts have often no equivalent in the Tharaka language, for their social system traditionally does not separate out sickness, health and medicine from other social domains in daily life - say politics, law, economics or religion.

One could solve the problem by a 'componential analysis' of Tharaka language in order to identify the logically arranged hierarchies of terms related to the semantic domain covered by native medical terms (Frake,1962). Though quite useful as a first step, this cognitive approach (1) would be of little help unless combined with non-language factors: who has produced such a semantic domain? What were the conditions for the social production of such a vocabulary? In short, we have to look at the actors in the medical setting of a given culture - those who perform specific medical roles, namely the patient, the healer and the community - in order to gain a better understanding of a medical domain. In fact, if cultural domains are categories of meaning attached to social situations (Spradley,1980:87), they are the product of social construction; and the medical domain,

like any other domain, is socially created.

The social construction of the medical domain implies a network of actors doing some activity in a certain place with some objects, for specific purposes. Among these actors, there can be specific occupational groups controlling the acquisition and application of some kind of knowledge related to a certain domain, whose work will certainly influence the main characteristics of the domain. Being considered 'experts', their definition of the basic problems of such a domain and of the ways of dealing with them will affect the domain itself. Therefore, we can assume that the social construction of the medical domain and social division of labour between expert and lay roles are two, often related phenomena.

Within the medical domain the healing role is certainly one of these cases of expertise whose influence is determinant in shaping the domain itself. It is a commonplace that the healing roles of non-literate and non-Western people tend to be highly generalized, contrasting with the extreme degree of specialization of Western biomedicine. The all-encompassing, inappropriate term of 'medicine-man', coming from early European observers of American Indians, was brought into the language to label this general healing role:

> 'The medicine-man is not only the primitive doctor but he is the diviner,the rain-maker,the prophet,the priest and in extreme instances, the chief or king' (Maddox,1923:25).

However, in many non-Western societies there is often a variety of specialized healing roles, some of which are also purely empirical. Failure by Western observers to recognize this

has often overshadowed the fact that in these societies, considering their general level of technology, medical roles may even seem overspecialized. Sigerist already realized that specialization of healing roles is 'by no means a phenomenon of late civilization, but it is frequently encountered among primitives' (Sigerist,1951:171). Some anthropologists noted the same fact: Rivers, e.g., described the elevated specialization of healing roles and treatment modalities in Melanesia (Rivers,1927), and Nurge found the same in a fishing-agricultural village in the Philippines (Nurge,1958). An interesting comparative issue is raised by Landy:

> 'It is not yet clear to me whether medical role specialization is correlated in an absolutely linear fashion with technological and social structural complexity.What does seem apparent is that dependence solely on the general practitioner seems to be characteristic of hunting-gathering or foraging societies and some, but not all, horticultural societies. There does seem to be a growth in healing role diversification in herding and agricultural societies, and, of course, a profuse flowering into myriad of specialties and subspecialties in industrial societies' (Landy,1977:416).

Paul Unschuld supplies us with an indirect answer to the problem raised by Landy about the existence (or not) of a linear correlation between medical role specialization and technological and social structural complexity: his theory, in fact, argues that medical 'professionalization' would tend to vary directly with societal size and complexity. His atypical definition of 'professionalization'(2) relates to 'the continuous attempt of a group in any community or society to gain more and more control over certain resources related to an occupational area' (Unschuld,1975:304). As a preliminary to his theory he also

makes a distinction between primary medical resources - namely, medical knowledge and skills, drugs and medical technology, medical equipment and facilities - and secondary ones which are material and nonmaterial rewards for medical practice. In this respect, professionalization in medicine refers to 'the continuing struggle of one or various groups for an ever increasing share in the control of medical resources available in any given community or society' (ibid.).

Unschuld distinguishes four levels of cultural development from his historical-anthropological point of view: the hunter-and-gatherer culture, the community of stable agriculture and domestication of animals, the pre-industrial society of the city and the industrial city-society (3). Therefore, in Unschuld's theory, there is a substantially linear development with a continuous shift of control over medical resources from the individual family in early cultures to the community and then to outside groups and organizations in highly developed cultures. This evolutionistic trend is debated by Press, who argues that 'tendencies' are not universal, and differences are not so clear-cut:

> 'While hunters and gatherers such as the Bushman may have no specialized healing roles, Australian aborigines do (albeit part-time). So, too, do tribesman and peasants . Peasant villages may have but a single curer or a number of specialized practitioners. The presence of healing organizations distinct from the family would seem to be a function of more complex societal type, but is certainly not limited to urban states. North American Indian medicine societies, the Zar cult of Ethiopian Amhara and even the participation of Guatemalan village political leaders in cures attest to the presence of non-kin-based health organizations in both tribal and peasant societies' (Press, 1980:54).

If the degree of social division of labour is obviously

related to the productive and organizational level of the society, this relationship is probably not so linear as Unschuld suggests: other factors beyond techno-economic complexity will also affect medical expertise in various societies, such as 'need, anxieties, and stresses generated by the interaction of an array of highly ideosyncratic environmental, social, and economic phenomena. An important goal of future classification attempts will be the sorting out of idiosyncratic from the more generalizable determinants of medical configurations' (ibid.).

To summarize, I would say that medical domains are the product of a social construction in which specific 'experts' exercise a strong influence; and the degree of specialization in their medical roles is related to a societal division of labour and to other factors affecting the more general development of historical societies. In the Tharaka context, the issue we have discussed at length can give rise to some interesting questions: are there specific occupational groups whose influence was determinant in the definition of indigenous medical domain? What are these groups and what are their features ? How was a Tharaka medical domain shaped by them ?

The matter is necessarily historical: we have to reconstruct how the past led to the present in order to give an historical dimension to our ethnographic account. But to do so, we need some reliable sources to tap. In the case of Tharaka, as for other preliterate societies until very recently, the only written sources on the past are colonial ones, while some Tharaka data are available only in a few recent ethnographic studies.

Certainly these two sources imply quite different historical perspectives: each of them has 'created' its own past. I shall try to single out the colonial view of the Tharaka medical domain from the Tharaka view itself as it emerges from the ethnographic data in order to answer the above three questions. The result will be, I hope, a better understanding of the way the traditional medical domain is defined by certain expert groups, and a less ambiguous way of looking at what is usually labeled as 'traditional medicine'.

Finally, I shall try to examine the way the Tharaka medical domain has changed as a consequence of the introduction of Western biomedical health care.

2.2 The Colonial Perspective: Witchcraft and Magic

All early colonial accounts agree on two facts: Tharaka people are famous among their neighbours for their 'black magic' and there are particular experts among them in the art of practising such magic, to the extent that they even teach apprentices from other ethnic groups like the Kamba, Mbere and Kikuyu.

> 'Among their neighbours, the Atharaka are reputed to be particularly versed in the practice of black magic, and this, more perhaps than their valour, also helped to keep them safe from the raids of the Akikuyu and Akamba,their neighbours in the southwest and the south. Many a medicine-man among the latter wanders up to Tharaka-land to be initiated into secret arts at a heavy price' (Lindblom,1914:3-4).

That Tharaka practitioners are very skilled in 'black magic' was so a widespread belief among neighbouring ethnic

groups that when Gerhard Lindblom, a Swedish scholar wishing to study them, wanted to visit Tharakaland, his Kamba carriers refused to accompany him:

> 'It was my intention to visit the former people, but my carriers refused to accompamy me. 'We are not afraid of the Tharakas'spear and sword', they said, 'but they will destroy us with their magic''(Lindblom,1920: 279).

An ancient custom (still alive in Tharaka during my stay) testifies how the diffusion of 'black magic' affected social relations:

> 'Tha Atharaka are very expert in the manufacture of poisons, and apparently use this knowledge very frequently for the disposal of their enemies. It is therefore the custom for a man to partake of a morsel himself before offering food to another. The custom is universal,and no offence whatever would be taken should a man forget to do this, and in consequences his guest pointed out the omission.I have noticed that the Akamba are very particular with regard to its observance when accepting food from the Tharaka' (Champion,1912:90).

It would be useless to look in the early colonial reports for any further distinction among Tharaka practitioners: the only two categories used were those of 'witchdoctors' or, in the best case, of 'medicine-man'. Consequently, any other internal form of indigenous therapy was not recognised because it was thought to fall under the category of witchcraft.

What were the underlying reasons for such a rejection of local medicine by British colonial officers ? The system of 'indirect rule' depended on the maintenance of ethnic groups and their customs: in principle, therefore, certain indigenous institutions were to be preserved if 'denationalization' was to be avoided (Turshen,1984). The simplest explanation, as Good states, was the threat of collective action that traditional

medical practitioners could provoke:

> 'For the colonial administration, the objective in dealing with the 'problem' of witchcraft was to minimize its effects on public order. Different strategies were employed in an attempt to control it, including prosecution, oathing, and public confession, and burning of the paraphernalia of witchcraft' (Good,1987:96).

How much such legal and social measures were really effective is doubtful.The'Witchcraft Ordinance' issued by British rulers in 1925, defined a witch as 'any person who holds himself out as a witchdoctor able to cause fear, annoyance or injury to another in mind, person or property, or who pretends to exercise any kind of supernatural power, witchcraft,sorcery or enchantment calculated to cause such fear, annoyance or injury (...)' (Witchcraft Ordinance, 1925). The vagueness in the wording of the Ordinance is quite evident: colonial administrators' reliance on undefined and stereotyped English terms like 'witchdoctor', 'supernatural power', 'witchcraft', 'sorcery' or 'enchantment' created a semantic and conceptual tangle. As Ann Beck points out, 'the wording was deliberately vague because the colonial officials did not have a clear idea of the functions attributed to the traditional healer'(Beck,1981:63).

The result was that the Witchcraft Statutes of Kenya (and other East African territories) failed to define the real meaning and the identity of a 'witch' for legal affairs (Mutungi,1977): the colonial codes never adequately comprehended the identifying characteristics of a 'witch' (5). The Native Tribunals, instituted under the provisions of the Native Tribunal Ordinance in 1930, dealt with very few cases of 'witchcraft', while the most frequent cases were of non-payment of Hut and

Poll-Tax.

More important for our purpose, were the effects at the medical level. The connotations of such a word as used in everyday life and in literature overlooked the identity, variety, interrelationship and significance of actors and events on the indigenous medical scene. Reading early accounts of European explorers, missionaries and colonial officers, one might conclude that Africans had not been overly concerned with the search for health or the control of disease, but only with fatuous superstitions. The annual Medical Reports of Meru District offer a good example of such outlook, as Beck points out:

> 'The less developed areas of Meru in Kenya offered a good example of the close connection between ignorance, belief in spirits, the practice of witchcraft, and insanitary conditions. In 1926 the annual medical report painted a dismal picture of public health in the native reserve. (...) A few years later, in 1930, another obstacle to public health in Meru was reported. Witchcraft played an important role in the area. The people of Meru feared it and disliked it, but they believed in it. District Commissioner I.G. Hopkins suggested a 'simple' remedy, namely, education and civilization, to wean them from their belief' (Beck,1970:142-3).

It took several decades after the establishment of British medical services in Kenya before any interest in African medicine and the African healers began: government and missionary physicians occasionally came across evidence of traditional treatment in their daily practice and, when their attitude was not prejudicial, this stimulated their interest. It is the case of Stanley Bell, doctor in charge of Maua Methodist Hospital in Igembe (Northern Meru) from December 1940 to January 1950, who published a medical and social study of Meru people using the

data he collected during his long stay (Bell,1955). Though not specifically on Tharaka, his articles contain the first tentative description of the geographical and ethnological background of the Meru people; and, particularly, of their changing medical scene. His description of Meru beliefs and customs concerning illness is the first attempt to understand an almost entirely unexplored cultural domain of the indigenous culture:

> 'All phenomena have a cause, and causes not clearly self-evident in this world are related by the Ameru to the Spirit world wherein dwell the spirits of their ancestors, jealous for the well-being of the village and clan life. The Ameru most certainly are 'also encompassed about with so great a cloud of witnesses' that no actor or word, no failure in tribal ritual or respect, can be expected to pass unnoticed.
> Therefore, any disease which arises is explained in terms of the anger of the ancestor spirits, and as the result of breaking tribal rules regarding behaviour.It is at this point that the Meru man or woman must have assistance in discovering the hidden cause of the trouble, and what must be done to put the matter right again; and the person in Meru society who is qualified to give that assistance is the witchdctor.
> By a combination of knowledge of tribal lore and custom, an untaught psychological insight enhanced by experience, and some beliefs that the chance shapes of patterns of bones or other objects thrown out on the ground represent the will of the ancestor spirits, the witchdoctor retains his place in the community, fulfilling for it the function of confessor, healer and intermediary between this world and the other' (Bell,1955:249).

Although tentatively sketching the functions of local practitioners, even Bell is unable to go beyond the label of 'witchdoctor' for them. It is evidence of how the use of conventional English terms such as 'witch' and 'witchcraft' had shaped the indigenous medical domain in the minds of Europeans. But what matters is that such an attitude also penetrated in the minds of the early acculturated Tharaka generations educated,

after World War II, in missionary and government schools which openly condemned local medical practices and practitioners without even attempting to understand it. As Good writes,

> 'During the colonial period in Ukambani as elsewhere in Kenya and tropical Africa, the positive association of traditional medicine and traditional healers with community health was eroded through contact with a European language and culture and as a consequence of unprecedented social change.Seventeenth-century English occult words such as 'witch', 'wizard', 'witchcraft', 'sorcerer', and 'witchdoctor'... entered the popular idiom and were applied indiscriminately so that 'witchcraft' became a virtual synonym for traditional medicine and'witchdoctor'became the common (and always pejorative) term for an African traditional healer' (Good,1987:99).

The consequence of European dominance was thus that its ethnocentric definition of the indigenous medical domain, since the earliest years of its contact with African culture, degenerated to the level of mere caricature and stereotype at a popular level with a corrosive effect upon the integrity of indigenous cultural institutions. The colonial perspective on indigenous medical domain thereby became, to some extent, the 'local' perspective, re-shaping indigenous medical domain according to European categories and undermining the key roles occupied by local practitioners.

2.3 Ethnographic Insights on Emic Perspective

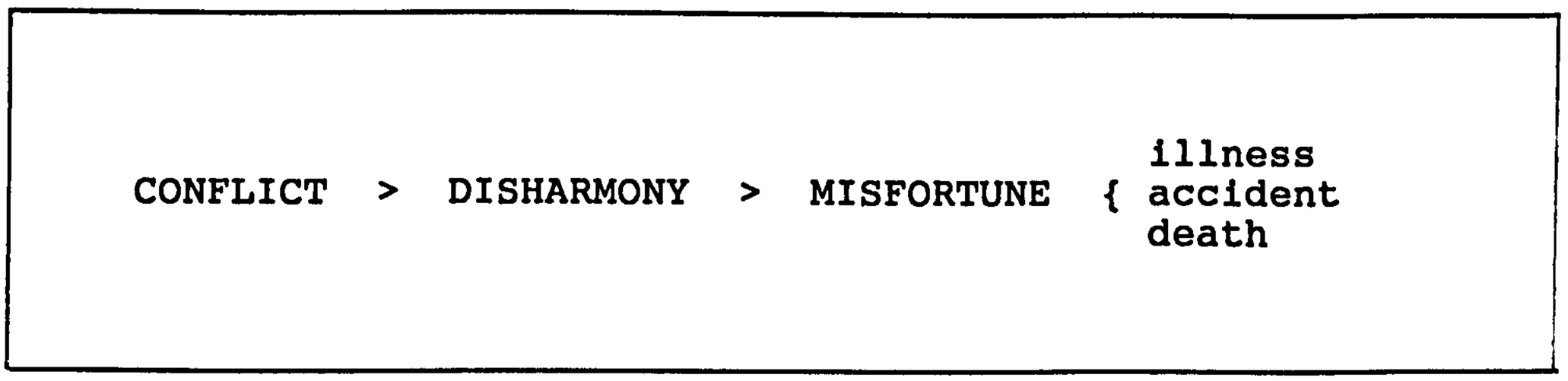
Archival and published sources written by European colonial administrators, medical officers and missionaries are certainly an 'acculturated' product and overreliance upon them

could conceivably create a distorted view of the Tharaka medical domain. This is the reason why we are now going to cross-check them through fieldwork done by anthropologists and historians using oral sources: even though the methodological approach followed by most of them was certainly more 'etic' than 'emic' (Pelto and Pelto,1970:54-66), we hope to be able to gain some insights with an emic perspective and grasp Tharaka categorization of their own medical domain.

Ethnographic research started in the late 1950s , a period when Tharaka was certainly no longer exactly as it was in pre-colonial times, even if the minimal acculturation process up to the late 1960s (as we have seen in Ch.1) preserved it from most colonial influence. Almost all the research work was conducted on topics other than medicine; however, findings often shed light on the cultural medical domain, too. Fadiman, for example, in his controversial work on Meru tribal warfare, delineated the Meru conception of conflict as the deep reason of illness. In fact,

> 'Conflict, whether between two living persons or a man and his ancestors, inevitably produced feelings of disharmony, expressed in wishes to harm another person or cause him some form of misfortune. This disharmony was believed in turn to be inevitably followed by natural calamity, usually taking the form of accident, illness or death. The explanation of any form of human misfortune was therefore attainable by seeking the cause of the original disharmony and resolving the conflict that had created it' (Fadiman,1982:10).

Fig.2.1 Meru causal chain of illness (Fadiman,1982)



The sequence conflict-disharmony-misfortune (fig.2.1) was, according to Fadiman, held to be by Meru people the causal chain responsible for illness, considered as part of the more general category of misfortune.This conceptualization seems to imply a rather static idea of a social system with no conflict, though it stresses the importance of a harmonious relationship between the individual, his community and the surrounding environment.

Moreover, it becomes quite difficult to circumscribe a specific medical domain in this conceptualization, unless we consider it as including all kinds of misfortune. The search for causation and the treatment of such misfortunes are then the fields of action of the ancient Tharaka art of Ugao. Volpini, though his gloss of 'magic' is rather restrictive, considers it as an essential part of Tharaka social system:

> 'Magic (Ugao) is one of the essential elements of Tharaka cultural system. It is a socially recognized activity, institutionally integrated with dynamics of social process. Its purpose is the welfare of the community and it is therefore opposed to evil, to witchcraft (Uroqi)" (Volpini,1978,1955).

It has been authoritatively argued that we cannot properly understand a medical domain unless we look at what

people actually do when sick (Kleinman,1980). When presented with any misfortune, - a person fallen ill, his livestock sickened, a child dead, a wife failing to conceive - a mutharaka (Tharaka person) knew that he could seek the origins of his troubles and the treatment for them by resorting to particular specialists available in his culture. I have already sketched the main features and functions of each of them in two preliminary reports on my fieldwork (Giarelli, 1986; 1988): I shall summarize my findings in the present tense without claiming any 'ethnographic present' (tab.2.1).

The muringia (pl. aringia) is the specialist in the art of divination (uringia). There is no apprenticeship or family inheritance for this role: usually women, they received their art through selection by nkoma (spirits) during a dream or a mystic

Tab.2.1 Tharaka medical practitioners

THARAKA NAME	ENGLISH TRANSLATION
mugao	healer
muringia	diviner
kiroria	foreteller
mutani	circumciser
mujukia	midwife

vision early in their childhood. The task of a muringia is the detection of the cause of a patient's problem by performing the ritual of uringia using a particular instrument called mbugu

(usually a small pumpkin full of seeds or a gourd with water or a mirror), after interrogating the patient.

The results of the divination process is the selection, within a limited range of etiological factors, of the one believed to be responsible of the illness or any other misfortune affecting the client. After that, the muringia usually refers the patient to a mugao (pl. agao) considered a specialist in that particular etiology. This class of specialists is certainly the most important one. Bernardi already singled out the figure of the mugao from that of Mugwe:

> 'The mugaa (Kimeru, n.d.a.) is a professional, a doctor, who knows (or is believed to know) all the reasons why one is sick. His job is to prepare the medicines and prescribe them on request. For this job, he is regularly paid '(Bernardi,1959:126).

While the Mugwe was a public dignitary, invested with the full power of official authority, the mugao is a private professional (even though, traditionally, he performed some public functions, especially during circumcision ceremonies) whose power comes from an art acquired by apprenticeship usually lasting quite a long time. Each mugao tends to become a specialist in a certain kind of etiology, according to his apprenticeship. The great majority of agao are men: this is probably due to the fact that the mugao has to move around a lot since patients are usually treated at home (by contrast, uringia usually takes place at the muringia's home), thereby restricting the role of women who are closely bound to the domestic sphere according to Tharaka custom.

Another important feature of the Ugao is the

fundamental ambivalence of its knowledge: the mugao must know how to bewitch (kuroga) in order to cure witchcraft (kurogora). The Ugao power may therefore be used for either beneficial or evil ends. It is for this reason that most agao refuse to teach their power except to adults who swear to use their knowledge for beneficial ends only.

The relationship between mugao and muringia seems to be ambiguous: on one hand, the muringia 'directs' the patient, after the diagnosis, to a particular mugao; on the other hand, the patient usually prefers to choose himself. The cooperation between mugao and muringia often does not follow 'official' lines but kinship (mwiriga) preferences.

Beyond the diagnostic and therapeutic aspects of Ugao, the Tharaka medical domain also includes preventive aspects: the foretelling (kuroria) of the future usually is an attempt to warn those concerned of impending calamities. This is the job of the kiroria (pl. aroria) who are consulted with regard to possible problems of harvest, war, childbirth, and illness. As Fadiman explains,

> 'Foretelling traditionally took two forms, interpretations of dreams and examination of goats. Both skills were hereditary in that the required knowledge was held within comparatively few families and transmitted from fathers to selected sons'(Fadiman, 1982:11).

Apart from the above specialists, two other roles in the Tharaka social system have some medical relavance: the mujukia and the mutani. Both practise their trade in connection with those life crises (childbirth and puberty) similarly marked in other societies by particular 'rites de passage' (Van

Gennep,1909): and both crafts are mainly empirical. The ajukia are not real specialists, since their role is widespread and 'diffuse': any woman who has had at least two or three children and has been attending the delivery of one of her women neighbours can carry out the work of the mujukia. It is substantially a display of solidarity by elder women of the neighbourhood: no type of formal apprenticeship exists for this work, which can be recompensed also by gifts (6).

Conversely, the mutani is a highly specialized role played by very few people during the two circumcision periods. His job is handed down from generation to generation by kinship: it involves years of apprenticeship and practice. The mutani possesses minimal therapeutic knowledge of some herbal concoctions in case of infection or bleeding: the most serious cases are directly referred to the mugao. Tharaka atani are quite famous among neighbouring peoples for their professional skilfullness and are often called for. For female excision, an equivalent female specialist exists, the mutani wa aka (lit.'the circumciser of women'). Nowadays, very few of them exist in Tharaka, since female excision is officially banned in Kenya and they must perform their work secretly (7).

To summarize, the findings of ethnographic research conducted during the last three decades show how complex is Tharaka medical domain and so how mistaken it is to label it simply as 'witchcraft'. Particularly, the range of specialists involved demonstrates an organic division of labour among different experts according to their specific functions

performed. Diagnostic function is exercised by the muringia; therapeutic function by the mugao; prevention is the substance of the foretelling activity carried out by the kiroria; the care and control of pregnancy, delivery and puerperium is the aim of the mujukia's activity; and a particular surgical operation is the specialty of the mutani. The range of specialists involved in production, maintainance and restoration of health is thus extremely wide in Tharaka: their division of labour appears organized around a gender and a generational order typical of this kind of societies. The gender order appears evident in the way the roles of mugao and muringia are allocated to men and women, respectively; and in the equivalent gender couple of the mutani and mutani wa aka. The generational order is particularly important in the allocation of the mujukia's role, where seniority and expertise are considered necessary related qualifications. There is less evidence of any order of the above kinds in the allocation of the kiroria role: although ~~the~~ most ~~part~~ of them are female.

2.4 The Coming of Biomedicine

Even the emic perspective delineated by ethnographic research risks being false or, at least, incomplete if it is not integrated with an historical excursus on the changes that have happened in Tharaka medical scene since the introduction of biomedical health care. We do not know whether the well-known series of epidemic diseases and severe famines that affected Kenya, as elsewhere in Africa, as a consequence of the colonial

conquest from the last decade of the XIX Century (Dawson,1979; Hartwig and Patterson,1978; Turshen,1984) also hit Tharaka or not. One of the very few written sources available, the Meru District Annual Report, states that "in 1913 the incidence of smallpox increased with serious outbreaks reported in Meru and Nyeri" (Meru District Commissioner).To what extent were Tharaka people also involved in this and other outbreaks of epidemics ? This will probably remain an unanswered question until specific research on oral sources be carried out. Possibly, the relative isolation of the region preserved it from more serious involvement. What is certain is that for quite a long period after the beginning of the colonial rule Tharaka and Meru Native Reserve as a whole remained largely unaffected by the development of modern medical services. In colonial Kenya the provision of basic medical care for the general African population 'was delayed again and again ... only after in late 1945 was a Ten-year Programme for the development of health and hospital services recommended with a financially generous endowment' (Diesfel and Hecklau,1978:26).

The history of the introduction of modern medical services into Kenya as described by Ann Beck (1970; 1974; 1981) shows that the neglect of African needs for health care grew out of the distinct, racially based three-tiered system of organized medical care with segregated African, Asian (Indian) and European facilities. Division of labour between government and missions in this system was quite clear:

> 'In the early phases of the colonial era, the government facilities concentrated on serving the

> European population, while the mission hospitals and clinics focused their work on the African population. The Asians (mainly wealthy individuals or groups) sponsored "Asian Wards" at both government and mission hospitals, and eventually separate hospitals'(Hartwig, 1979:122).

In this light we can understand why until after Independence, not even a single government health care facility was opened in Tharaka: the only two existing dispensaries (Gatunga and Matiri) were opened during the 1950s by Catholic missionaries. The missionary factor in the development of health services in Kenya is unquestionable: indeed, there was a relation of complementarity with the colonial sector (Mburu,1981:523). In Kenya, like elsewhere, healing (and education) went hand-in-hand with proselytization: both the Catholics and the Protestants recognized health work as potentially helping conversion. Therefore, missionaries opened up outposts in remote areas and larger health centres or hospitals in their more important areas: this is exactly the policy followed in Meru and Tharaka. This is the reason why it is better to consider the matter in the context of the whole district.

The three Christian denominations which established their stations in the district - Catholic, Methodist and Presbyterian - followed a tacit agreement of territorial subdivision into separate spheres of influence to avoid competition: the Methodists at Maua in the Northern part of the district; the Presbyterian at Chogoria in the Southern part; and the Catholic at Nkubu and Mujwa in the Central and Eastern part (Map 3). The missionary health care system followed the same denominational pattern, with the Protestants pioneering modern

medical work shadowed by the Catholics. Chogoria Hospital was established at the Presbyterian Mission station among the Mwimbi and Chuka in 1922; Beresford Memorial Hospital was erected at Maua in 1930 covering the Igembe and Tigania areas; finally, Nkubu Hospital started in 1950 in the Catholic station among the Imenti and gradually expanded its catchment area eastwards down to Tharaka. Only in the last ten or fifteen years has Tharaka become a contested area among the three denominations (plus some new syncretic sects), each of them establishing its own dispensary.

On the government side, we know that even though the colonial rulers became gradually more active after World War I - passing the Public Health Ordinance in 1921 and the Native Authority Ordinance in 1924 which created Local Native Councils to deal also with health matters at the local level - very little was done for rural health services because of budgetary constraints and poor cooperation from indigenous people (Gilks, 1933; Adalja,1962). A colonial report states that, 'owing to the general state of poverty no rate was collected by the Meru Council and the maintenance of the existing services was consequently difficult' (Kenya Colony and Protectorate,1933:37). Any cooperative spirit of partnership between the Local Native Councils and British officers was definitely dampened when the government reasserted its authority during the 1930s (Munro,1975:178).

A Native Civil Hospital was opened by the government in Meru town in 1913, but it ~~was~~ always functioned very poorly and was poorly staffed. After World War II, with the new policy of

developing rural facilities in native lands (Beck,1981:22), there was a considerable shift in the health focus from curative to preventive and promotional aspects. However, since the burden of financing, building, equipping, and staffing rural health services remained with the African District Councils (this was their new name after World War II), the new idea was never properly implemented. This policy remained in effect until 1969 (six years after Independence) when a new bill shifted responsibility for health and other matters from the District Councils back to central government.

Two new government health centres were then built in Tharaka at Chiakariga (1969) and Marimanti; while some local dispensaries (Tunyai, Kamanyaki, Nkondi, Kathangacini, Thurima) were opened during the 1970s and 1980s, but they continued to suffer from a serious lack of both trained staff and supplies.

The history of the introduction of biomedicine in Meru District proves the pragmatic attitudes of this as of the other African peoples towards the new kind of medicine:

> 'Into these several indigenous systems of medicine,therefore, Western scientific medicine came as a yet further alternative medicine. The African, being pragmatist,looked for a system that worked, and if one traditional remedy failed then another could be tried and so on until eventually Western medical treatment could also be given its chance. The reason for advance of Western scientific medicine in Africa was was no doubt that,like most systems of alternative medicines that gained some acceptance, it fulfilled a particular need not being met by the more established system' (Orley,1980:127).

Evidence of attendance levels at hospitals and rural facilities in Tharaka and Meru District seems to show a pattern

of gradual acceptance and steadily increasing demand by the local people as time goes on. Dr.Bell, of Maua Hospital, tells us that,

> 'When hospital were first established in the Reserves there was great suspicion of them, and the people showed much hesitation about accepting more than out-patient treatment. This suspicion was associated with fear of putting oneself in the care of a foreigner, and fear of 'mugiro' or tribal uncleaness for the foreigner did not destroy his 'house' if someone died within it! On the death of an in-patient, therefore, most of those in the hospital would demand to be discharged or would abscond' (Bell,1955:258).

But the conflict between some traditional beliefs and the organization of modern health services did not preclude the increasing utilization of modern services by Meru people. Various colonial reports stress this fact for Meru Government Hospital:

> 'It would appear that native prejudice against medical treatment is gradually breaking down, which is evidenced by the fact that the out-patient increased by 20 per cent. The Local Native Council showed great interest in public health matters. There are ten dispensaries in the district' (Kenya Colony and Protectorate,1933).

Medical statistics showed that in 1933 at Meru Native Reserve Hospital the in-patient were 1,355, the out-patients 16,510 and the out-dispensary patients 90,861. Even in the following years attendance continued to increase to the extent that another colonial report in 1937 states that,

> 'It is evident that the Meru people - one of the least advanced tribes in the Province - appreciated the medical benefits provided at the Meru hospital, the two hospitals under missions auspices and the many dispensaries in the district' (Kenya Colony and Protectorate,1937:116).

In spite of this triumphal tone, the medical situation in the district did not seem to show a real improvement; and the problem of dual use by Meru patients of modern and traditional health care arose in these years,

according to what the District Commissioner of the time reports:

> 'The year has been notable for the severity of various epidemics, disentery, measles and chickenpox being particularly common. Medical work is still handicapped in some areas by the delay in reporting such cases as dysentery and in bringing them for treatment, it being only after the local medicine-man and the sacrifices of goats have failed to cure that the relatives of the sick are prepared to see what European skills can do - generally, by then, too late' (Kenya Colony and Protectorate,1934:84).

This pattern of utilization with traditional health care as first and modern medicine as second choice is confirmed by Dr. Bell's acute observation:

> 'But as yet the majority of the people are little changed in their beliefs about disease, its cause and treatment. Many of the patients who come to hospital have already had various native treatments administered to them. (...) In many cases it seems that the belief is that the European doctor and his helpers can cure the symptoms, but the witchdoctor is needed to explain and assist in removing the real cause of the disease' (Bell,1955:258).

Another problem that hampered the utilization of modern health facilities was that, while government facilities were free of charge, missionary ones charged in- and out-patients:

> 'In Meru, despite the presence of a Government and three mission hospitals, the facilities for a population of 350,000 are relatively small. The missions perforce have to charge, which somewhat restricts the enthusiasm to become in-patients at these places' (Kenya Colony and Protectorate,1955).

2.5 Ethnomedical System or Plural Health Care Configuration?

At the end of our historical excursus, I would try to answer the questions we asked at the beginning of the chapter in the light of the ethnographic data presented. Undoubtedly, the

Tharaka definition of health appears wider than the Western one, to the extent of questioning whether there is a definition of a 'medical' domain. The nature of health work in this society embraces, as we have seen, a wide series of activities involved in the production, maintainance and restoration of health, in the care and control of birth, in the prevention of misfortune of any kind (not only sickness), in the control of successful socialization. The nature of the work performed by all the health practitioners we have examined goes well beyond the suffering of the body as the usual sphere of intervention of medical relevance. How can we thus define the series of health care activities performed by them? What boundaries can we trace to understand their real nature in the Tharaka cultural context? A review of the relevant literature on the topic can help us to draw a proper theoretical background to answer our questions.

One of the most insightful papers into our rather uncritical reliance on 'common usage' for the definition and application of key concepts and terms relevant to the comparative analysis of health care activities still remains Irving Press' article on definition and classification of medical systems (Press, 1980). The question of 'what is' a medical system and what constitutes it appears in all its problematic nature in his discussion: and, first of all, the issue of what is 'medical' is well raised. The realization that, in the panorama of problem orientations and perspectives existing in Medical Anthropology, there is still no overall unifying paradigm, makes it necessary to review some of the major definitions and models proposed. One of the first questions is whether cultural beliefs and social practice

directed toward supernatural phenomena should be included in any definition of 'medicine' and 'medical'. Opinions differ widely: there is the 'exclusive' party (8) that stresses only the naturalistic rationale and practice of medicine; and there is the 'inclusive' party (9), which grants a 'medical' status to all non-Western health practices labeled as 'ethnomedicines'. Press profoundly disagrees with the rather ethnocentric, Western-biased characteristics of this latter definition, proposing to retain it only to describe a type of study that includes biomedicine too, namely the 'ethnomedical approach'(10). Other definitions general enough to encompass all types of medicines and treat them as institutional equals, still appear problematic (11), as is the 'rather uncritical interchangeability of the terms medicine and medical system'(ibid.:46). Landy's distinction (1977:131) between 'medicine' as the cultural manifestation of health-related phenomena (values,rules, material and means) and 'medical system' as the social manifestation of the same phenomena (organizations, technology and personnel) does not appear convincing and is at least partially overlapping; moreover, it 'downgrades the importance of cultural elements' vis a vis the medical system' (Press,cit.), instead of assigning equal importance to both social and cultural aspects of medical phenomena.

A further, much discussed problem is the definition of what is a 'system'. As Press puts it, 'How diverse can be the sub-elements of a medical system and still constitute a single system?' (ibid.) The definition of 'pluralistic medical systems' as proposed by Leslie for Asian societies (1976:357) and of

'ethnomedical systems' proposed by Good for African societies (1987:22-4), appear debatable. Press objects that the concept of 'system' has a well-established traditional meaning as 'a functionally integrated entity with intercommunicating parts' (Press, cit.): thereby, using this concept with reference to the mere presence of alternative elements of medical care within the same society without any linkage between them appear counterproductive.

> 'Thus, the notion of a "pluralistic medical system" containing sub-systems with diversely based paradigms and little or no two-way communication and influence among the parts does significant violence to our concept of "system" ' (Press,cit:46-7).

From an etic point of view, at least, treating each of the co-existing medical traditions within the same society as a true system appears an uncorrect assumption. And from an emic point of view? The question is sound, since Kleinman and the other theorists of the 'ethnomedical approach' consider their concept of system as evolving from people's perception and health-seeking behaviour (Kleinman, 1973:62; Good, 1987:22). However, mere perception and use by people of elements of diverse systems, differently defined as 'dual use' or hierarchy of resort' (12), need not imply - Press states - that all are viewed as parts of a single, functionally integrated, system. Rather, it shows people's pragmatic attitude to 'healer-shopping', once the culturally prescribed behaviour (if it exists at all!) has failed. In conclusion, Press suggests we should replace the expression 'pluralistic medical system' with 'plural or pluralistic medical configuration' when it refers to societies considered as the basis for multisystemic medical profiles;

and we should reserve the concept 'medical system' for 'a patterned, interrelated body of values and deliberate practices, governed by a single paradigm of the meaning, identification, prevention and treatment of sickness' (cit.:47).

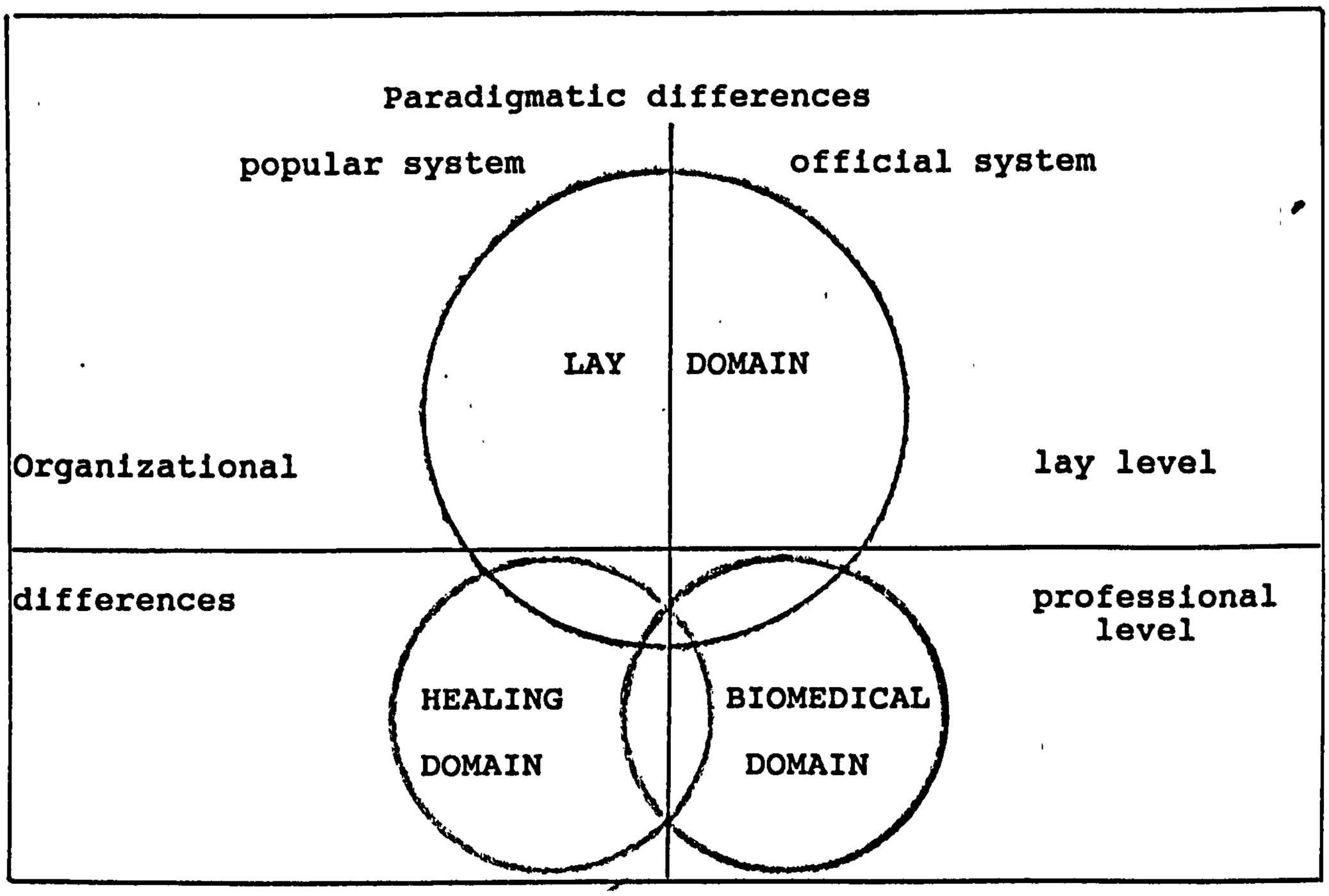
The third topic of discussion, after the nature of what is 'medical' and what is a 'system', is the inner structure of a medical system. Here the dominant paradigm is undoubtedly the tripartite division, proposed by Kleinman (1980:49-60), of local health care systems into three main sectors: the popular, the professional and the folk sector. An adaptation of this tripartite division is proposed by Good (1987:23-4), who substitutes 'biomedical' for 'professional' and 'traditional' for 'folk' sector. Both classifications appear unsatisfactory. Press claims the differences between these three sectors are 'anything but clear, and few terms have been as overworked and underdefined' (ibid.). Particularly, he shows the ambiguities in the different ways in which both the terms 'folk' and 'popular' are used in accounts of medicine (13). Of particular importance is his effort to distinguish, within the three sectors proposed by Kleinman and his followers (who are often not as shrewed as him), whether the boundaries among them are traced on the basis of paradigmatic differences or are instead based on organizational differences. In the first case, the distinction reflects a substantial difference in the concepts of health, sickness and medical treatment; in the second case, the distinction is simply base on a different degree of access to medical resources. But a different level of expertise and access

to technical and medicinal remedies does not necessary imply a substantial paradigmatic difference. This means that,

> '(...) if practitioner and layman agree that what each does in response to illness is proper and effective even though dissimilar, and if the response of both reflects a common model of explanation for the practices and outcomes even though these may differ in degree of sophistication,then the lay response is but one level of a patterned hierarchy of responses to illness, one element of a single system. It is not paradigmatically variant' (cit.:48).

On the basis of the above considerations, I argue that if the distinction we trace within the Tharaka medical domain is based upon paradigmatic difference, than we should view it as consisting of two sectors only: the dominant official sector of biomedicine and the popular, indigenous sector, each with its own lay and professional levels. In fact, there is both a lay level of the official biomedicine (shop drugs, self-medications, etc.) and of the popular sector (herbal home remedies); whereas there is both a professional level of biomedicine (regular practitioners) and of the popular medicine (traditional health practitioners). On the other side, from an organizational point of view, we can speak of folk, popular and professional as terms referring to the different degree of expertise and access to medical resources by traditional practioners, lay people and modern practioners respectively. In fig.2.2 I try to express visually in a synthetic way this double, overlapping classification underlying Kleinman's tripartite system. I prefer to use the term 'plural health care configuration' instead of 'pluralistic medical (or 'ethnomedical') system' for the reasons discussed above; I use 'health care' instead of 'medical' because it is a more comprehensive term for the different roles involved

Fig.2.2 A model of plural health care configuration



in health work in Tharaka besides those of diagnosis and therapy. I use 'configuration' instead of 'system' to avoid any inappropriate use of the term (which remains valid for a paradigmatically coherent medical array); and, finally, I use 'plural' instead of 'pluralistic' to avoid treating the official and the popular sector as equivalent (14). I hope, in this way, to offer a better understanding of the way the medical domain is shaped in Tharaka culture: to test this, some more questions need to be answered. For example, to what extent does this etic model correspond to emic concepts and behaviour? What, from the Tharaka point of view, distinguishes lay and professional

domains? How are the two paradigms, the official and the popular systems, perceived as different?

FOOTNOTES TO CHAPTER TWO

1) For an interesting comparison of the results of the application of emic/etic methodologies to health problems in the Ethiopian context, see Messing,S.D. 'Emic and Etic of Health Problems in Ethiopia', in Grollig and Haley (eds.),1974.

2) In the Anglo-American literature,the term 'professionalization' is usually utilized to describe two phenomena: the transition of an occupational group to a new, socially recognized status; and the period of socialization of a neophyte into a profession.

3) According to Unschuld, at the beginning we have the hunter-and gatherer cultures, where control over the two types of resources still lies with the general public: this is identified with kinship groups. Since this small size of collectivity does not permit specialization, the available knowledge is handed down from generation to generation on a collective, familial basis: thereby, no regularly practising medical specialist with an explicitly distinct career can exist outside the family.
Things started changing with the neolithic revolution and the rise of communities with stable agriculture and domesticated animals. Here, where relatives and non-relatives form a tribal community,the increasing division of labour and specialization fosters the emergence of medical practitioners in the medical area: 'The process of acquisition of control over medical resources by groups outside the family evidently is accompanied by a loss of medical knowledge by the family.(...) Within the framework of our theory, it is evident that it is not the society which decides to create an institution for the handling of a recognized need, but that a group of individuals takes control of those primary resources relevant to the need and later - if successful - becomes approved by society as an institution' (ibid.:305).
The level of distribution of medical resources in this second stage embraces four different groups:the family, still holding considerable control over dietary patterns and even forms of treatment; groups of practitioners partially specialized in 'profane' techniques, such as snake-bite curers, bone-setters and midwives; the emerging shamans, medicine-men, sorcerers, whose practice is often restricted to the treatment of psychological, problems of deviance for the purposes of social control; and, finally, the community as whole performs some medical activities, such as tribal rituals with medical-hygienic purposes.
The third cultural category is the pre-industrial society of the city, where more and more resources are shifted from the individual and his family toward formal organizations: 'every individual became alienated from a wide span of resources it had previously possessed and controlled within the framework of the family' (ibid.:306). In this context,

medical treatment is the result of 'an alien force', 'with the individual at its mercy' without any control on its outcome. During this period of pre-industrial city society, possession and control of medical resources is still distributed among differents groups, with a strong tendency toward secularization of medicine. Increasingly, the clerical group, successor to the shamans, is deprived of these resources by new, profane specialists: this process implies a steady constriction of the magico-religious sphere in medicine.
Finally, we find the industrial city-society, where the family has been deprived of almost all resources which are shifted to formal organizations.

4) Cf. Jaspan,M.A. 'The Social Organization of Indigenous and Modern Medical Practices in Southwest Sumatra', in Leslie (ed.),1976.

5) For an interesting discussion in 1930s on various aspects and shortcomings of the Witchcraft Ordinances in Kenya and in the other British colonies, cfr. Orde Browne, 1935 and Clifton Roberts, 1935.

6) The non-professional nature of the mujukia's activity is also marked by the fact that she will later be invited to attend the wedding ritual (ujukania) of the newborn.

7) Once a Kanu chairman of South Tharaka told me proudly that 'Tharaka were the only people among the other Meru sub-tribes who refused to sign the agreement banning female circumcision proposed in 1950s by colonial authorities' (Field notes,1986).

8) Among the representatives of this 'party' are Mitchell,1977 and Croźzier,1975.

9) Among the representatives of this 'party' are Hughes,1968 and Chrisman, 1977. The use of the label 'ethnomedicine' to denote all non-Western types of medical systems is common among the historians of medicine: cfr. Sigerist,1951 and Ackerknecht, 1946.

10) A suggestion best put forward by Kleinman (1980),Leslie (1980) and the other theorists of what Good calls the 'ethnomedical approach'(1987:18).

11) For example, Glick's apparently more comprehensive and workable definition as 'a patterned set of ideas and practices having to do with illness'(1967); or Dunn's (1976) proposal to include only deliberate behaviours that affect health, not incidental ones with latent health functions (taboo, purity ritual,etc.). For an in-depth discussion of how far is traditional medicine to be considered a system, cf. Last,1981.

12) The topic of 'dual use' is well-documented in the literature: cfr. Press (1969) as one of the first to discuss it; the

hypothesis of the existence of a 'hierarchy of resort' was first proposed by Romanucci-Schwartz (1969).

13) Press points out that the term 'folk' has been used in three different ways: 'a) as any system other than Western biomedicine; b) as any system other than a written medical system; c) as any system that varies from the official (always written, usually Western biomedcial) system in the community or the society' (Press,cit.:48). Also the concept of 'popular medicine' can be used with two different meanings: 'all medical practices performed by other than officially sanctioned professionals of a medical system, and which do not directly contradict the paradigm of the system' or 'those beliefs and practices which, though compatible with the underlying paradigm of a medical system, are materially or behaviourally divergent from official medcial practice (ibid.).

14) This topic will be discussed in more depth in 9.1.

CH.3 LAY KNOWLEDGE AND HEALTH-SEEKING BEHAVIOUR IN TWO THARAKA VILLAGES

3.1 Research Approach and Setting

According to Good (1987:228), there are two basic approaches to the study of people's health-seeking behaviour: population-based studies and utilization survey. Whereas the former focus on the features and behaviour of all members of a sample population (healthy and sick), the latter investigate only the population that actually visit a particular health care provider or facility (traditional or modern). Each of the two methods has its own advantages and disadvantages (Good,cit.:228-9): for the specific purposes of my work - that is, to study the role of lay medical knowledge in health-seeking behaviour - I chose to follow the first approach, since it provides a major opportunity to observe people's behaviour throughout a course of therapy and to differentiate actual individual and community patterns of behaviour.

The two research sites where the population-based study was conducted are named Kibuka and Kariekajeru (Map 5). One of the main problems an anthropologist faces in field work is to gain full acceptance by the people. To investigate health-seeking behaviour inevitably involves intruding in the everyday life of the people: to make the research role as un-intrusive as possible is a very important precondition for successful anthropological work. To achieve this, one must gain the confidence of the people by showing oneself to be really trustworthy. Therefore I first

explained to the elders and the local political authorities (Chief, Subchiefs, and KANU leaders) of my two chosen sites what was the purpose and objectives of my work; then I arranged feasts with traditional dances and drinking of nchobi (local beer); finally, I started living in a hut the subchief offered me in Kariekajeru area, too far from my home (70 Km) to travel the whole distance every day.

After that, I selected a core sample of 50 households (25 in each of the two areas) to be observed. Using a check-list I recorded who became or was recently sick in each household, what sickness and what therapeutic choices were taken or were planning to be taken. During this period, which lasted about three months, I visited each household almost every week, unless an episode of illness made it necessary to make more frequent visits. I also observed the other socio-economic and daily activities of the people in order to uncover general behavioural patterns. I usually joined in family parties, public meetings, rituals and discussions. Participant observation was very important during this stage to gain a rough idea of what Tharaka people usually did to cope with an illness episode. Finally, I particularly followed and collected the stories of the most interesting cases I came across in the observed samples (Tab.3.1).

I shall first outline the main characteristics of the two sample areas before examining the research findings. Kibuka is a relatively recent settlement (20 years old) of 61 homesteads in Tunyai Sublocation, mainly occupied by Tharaka people who moved here from the extreme South of the country, from as far as beyond

Table 3.1. List of illness episodes

N.	NAME	SEX	AGE	VILLAGE	EDUCATION	ILLNESS
1	Kaboro	F	34	Kibuka	Illiterate	infertility
2	Ciampui	F	35	Kibuka	Illiterate	infertility
3	Kaburi	F	34	Kibuka	Illiterate	infertility
4	Kanyoro	M	14	Kibuka	Standard V	mental confusion
5	Kambura	F	23	Kibuka	Standard III	abdominal pains
6	Kiguara	F	70	Kibuka	Illiterate	joint pains
7	Kaindi	M	50	Kibuka	Standard II	head/stomach ache
8	Muthamia	M	60	Kibuka	Illiterate	cough
9	Nyamu	M	25	Kibuka	Standard IV	chest pains
10	Mati	F	45	Kibuka	Standard III	stomach/headache dizziness
11	Gatembi	F	55	Kibuka	Illiterate	cough,stomach ache
12	Tabitha	F	70	Kibuka	Illiterate	nyongo,diarrhoea
13	Kimbu	M	40	Kibuka	Standard VI	backache,gichonono
14	Ruguru	F	70	Kibuka	Illiterate	headache,joint pains
15	Muthoni	F	17	Kibuka	Form I	swollen leg
16	Kamene	F	40	Kariekajeru	Illiterate	miscarriage, headache
17	Kiaira	F	50	Kariekajeru	Illiterate	blindness with swollen eye
18	Mukauru	F	50	Kariekajeru	Illiterate	heart problem, joint pains
19	Nkima	F	45	Kariekajeru	Illiterate	headache
20	Nkathe	F	75	Kariekajeru	Illiterate	swollen leg
21	Kagondu	F	55	Kariekajeru	Illiterate	joint pains,bloody diarrhoea,dizziness
22	Gakunyi	F	50	Kariekajeru	Illiterate	miscarriage, joint pains
23	Cianjoka	F	23	Kariekajeru	Standard III	infertility
24	Karea	F	26	Kariekajeru	Standard IV	infertility

25	Jevina	F	24	Kariekajeru Standard II	infertility
26	Gaichu	M	55	Kariekajeru Illiterate	impotence
27	Karigi	F	25	Kariekajeru Illiterate	backache, bloody diarrhoea
28	Ntue	M	50	Kariekajeru Illiterate	armache
29	Karemi	F	23	Kariekajeru Standard III	stomach/backache dizziness
30	Kaura	F	35	Kariekajeru Standard I	infertility

N.B. The real names of the people have been changed to avoid any possible identification.

the Tana river (Thagichu). Located on two sides of the main road which passes through Tharaka, transport and communication are much easier than elsewhere in Tharaka: there are some matatu (pick-up taxis) which daily ply between the area and Meru town. Kibuka is also situated in the highest and most fertile portion of Tharaka; and there is a certain number of modern health care facilities in the neighbourhood - a governmental health centre (Mitunguu), two dispensaries (one governmental, Tunyai and the other missionary, Marebe), and Nkubu and Chogoria hospitals are not far away (20-25 Km).

Kariekajeru, on the contrary, is a village of 40 homesteads at the southeastern end of Tharaka in Kamanyaki Sublocation, a semi-arid valley with a rather torrid climate and very low rainfall. It is one of the oldest Tharaka settlements, in the historical core area of the first immigration from Mbwa Island, according to the Tharaka myth of foundation. The main road is a long way off and there are practically no transport and communication facilities, since the only track is in a very poor

condition (many times I had to repair it in order to pass). The only modern health care facility in the area is a governmental dispensary built with mud and a roof of mabati (corrugated iron); most of the time it is completely lacking in any medicine and is periodically closed because of the absence of any personnel. Since other modern health facilities are far from here - the closest are Chiakariga governmental health centre and Materi Catholic dispensary - and there is no vehicle at all in the area, many times I took sick people to seek help.

As is evident, the two areas should be representative of two quite different kinds of cultural dynamics: one relatively 'acculturated' and modernized with a wider spectrum of therapeutic options besides traditional facilities (Kibuka); the other, more isolated and traditional with very limited opportunities by way of modern health care facilities (Kariekajeru). My purpose was to examine if there was any significant difference between the two areas in the health-seeking behaviour of people living in them.

The different situation of the two sample areas is also reflected in the education levels of the people interviewed: as is shown in tab.3.2, Kibuka has a slightly higher level of education than Kariekajeru. This appears the only significant difference in the personal data of the people involved in the illness episodes we collected: the other variables, such as age and sex, do not significantly differ. What is most significant is the prevalence of females over males and of adult and elders over young people and children in both areas. Given the limited

number of episodes studied, this cannot certainly be considered epidemiological data. In my opinion, the striking absence of children in the sample collected can be explained by the mainly acute, self-limiting and short-term nature of the health problems prevailing among children: such case simply did not occur, I believe, in the two sample areas during the period under observation (1). The prevalence of females over males can be explained by reference to cultural behaviour: men are more difficult to find at home, since they usually leave early in the morning and sometimes do not come back even for days. This made it much more difficult for me to meet and interview them; so too did their greater reluctance to talk about their health problems. All these factors can, at least partially, explain the prevalence of episodes involving female adults or elders, episodes involving mostly chronic, long-term illnesses.

Tab.3.2 Personal data of the people interviewed in the two areas

VILLAGE	SEX		AGE*			EDUCATION			TOTAL
	M	F	0-20	21-49	50-	ILLIT.	PRIM.	SECOND.	
Kibuka	4	11	2	7	6	8	6	1	15
Kariekajeru	3	12	-	8	7	10	5	-	15
TOTAL	7	23	2	15	13	18	11	1	30

* The age is approximate as regards elders:the three age-classes at least partially correspond to the Tharaka age-grades of young people (0-20), married adults (21-49) and elders (50-).

3.2 An emic perspective: people's interpretations of events

The episodes (summarized in Appendix C) contain an apparently random set of events related to the display of illness: but how do Tharaka themselves explain these behaviours? What kind of interpretations do they offer to account for them? What kind of knowledge are they based upon? There is, first of all, a terminological problem:when a Tharaka person uses the expression 'kwajua', getting sick, he implies a serious problem, probably long-standing and with severe consequences in terms of impairment or disability. Conversely, the term kwajua is not used to denote a simple ailment, or an unwell person with a temporary problem of no serious consequence.

This distinction between what we could term the 'ill' and the 'unwell' is paramount in understanding whether physiological and psychological changes of a person's condition will probably be defined as 'illness' or not in Tharaka. In a society where life's problems are not medicalized and the relationship with the external environment still needs a strong degree of 'coping ability' in order to survive all the adversities, there is a great probability that simple, slight ailments would not even be taken into account. If we add that malaria is epidemic in Tharaka and it is the most common disease, especially after each rainy season (2), we can understand why the unspecific symptoms of this disease (headache, stomach ache, dizziness, etc.) are often overlooked by the people. When I was moving about the homesteads in the two research sites questioning people about their health problems, I early realized that a person, to be

allowed to enter upon the sick role termed '<u>kwajua</u>' in Tharaka (3), should be seriously and chronically ill. This is another reason why male adults and young people are mostly absent in the reported illness episodes: their simple ailments are not even taken into account. The prevalence of female adults is then due to the presence of many cases of infertility: a highly significant problem in Tharaka, as in any other African society where fertility is a social value.

The above can probably explain why in Tharaka the sick role can be considered almost a prerogative of elders and female adults whose social status is likely to be considerably lowered as a consequence of their real or supposed infertility (male infertility is not culturally recognized); or, as was my impression in many instances, female adults were seeking relief from a heavy burden of work (cultivating, fetching wood and water, cooking, child-rearing, marketing, etc.). Therefore the boundary beyond which certain symptoms are labelled as illness and treated as such, is very high in Tharaka because of a series of cultural, social and epidemiological factors. Only symptoms marked by their severity and duration will in fact be taken into account because of the impairment or disabilities (unable to walk, to work, to sleep, to eat, etc.) that results. These disabilities and not the symptoms themselves are what are mostly feared by people: as Gakunyi states, 'Someone does not fear an illness (<u>murimo</u>), but one can fear losing strength (<u>inya</u>), becoming weak and unable to work' (Case 22:1).

Pain perception becomes another important gauge or criterion

of illness: if there is no or only a little pain, no symptom will really be considered by Tharaka people. An acute or long-standing pain is the necessary condition because a symptom can then be labelled as such and acted upon. A murimo (illness) is a painful condition requiring help: conversely, it is not. This is clearly expressed in the spoken usage: 'murimo' means both 'illness' and 'pain' in Kitharaka. The vocabulary of distress, used by the people to express various illness labels, is then mostly based on the expression 'murimo gwa - ' (illness/pain of -) followed by the specifically affected part of the body : murimo gwa kiongo (headache), murimo gwa mugongo (backache), murimo gwa nkoro (heart problem), murimo gwa ndamu (menstruation problem), etc.. Illnesses which are differently expressed imply a condition where pain is not the main criterion: such as 'nthiurura' (dizziness), 'nkoma' (madness), 'kirumati' (stomach ache intended as a disorder), 'mutigiri' (leprosy), 'nyongo' (type of malaria), 'nthata' (infertility).

This vocabulary of distress is based upon an anatomy and a physiology: the first consists of a gross division of bodily parts (head, neck, stomach,etc.); the second is a dynamic conception of its functioning based on the role played by strength ('inya') represented by blood that flows through the veins. This idea of 'ndamu' (blood) as a vital, dynamic element that interconnects all the bodily parts is recurrent among Tharaka: it is also used to explain the diffusion of worms (njoka, lit. 'snakes') in the body, since they are believed to move through the veins.

But how are the illnesses classified and explained by

Tharaka people? Firstly, there is the acknowledgement of an empirical, 'natural' level of causation, in which at first glance mostly symptoms are classified. Both biological and environmental agents are held responsible for the occurence of any illness at this level: a cold, bad food, fatigue, stress are commonly recognized etiological agents. As Kagondu states, 'I think that my backache is caused by the heavy tins of water I usually carry; while headache is due to poor feeding' (Case n.21:2).

This 'natural' level of explanation is usually employed by Tharaka people as a first line of causation: consequently, action undertaken to cope with problems classified as such will employ 'materia medica', using herbal treatment, shop-bought drugs, or resort to the dispensary or hospital. If the treatment is successful and the illness disappears, this primary interpretation is confirmed by the course of the illness. But if it does not, this initial explanation starts to be questioned and a doubt arises in the minds of people: is there 'anything else' involved? After all the 'pilgrimages' - as described in the accounts of the episodes -from one health care facility to another one with no success, the afflicted patient starts thinking of her problem in terms of 'something else' whose nature is unknown. This involves a second, 'unnatural' level of explanation, whose discovery requires resort to a specialist: the muringia. This figure (usually a woman) is deemed to be able 'to see' what common people cannot see. At the end of any divinatory session, the result is always a label of a specific

illness, which implies a certain explanation and requires a particular course of action to be undertaken. It is not necessary for the ill person to attend herself at the session: in many instances, as in the cases of Kamene (Case 16), of Kimbu (Case 13), or of Karea (Case 24), I found it was a close relative (the husband, the mother, a daughter, etc.) who went.

The number of labels attached to the illness by the muringia varies within a limited range: no more than ten. The meaning of these labels is unknown to the lay people, but what is important is that they are passed down from the muringia to the patient with a minimum of etiological explanation and an indication about the course of action to be undertaken:

> 'I cannot say what 'gendaga' is because I do not divine. The muringia never told me what gendaga is: I was only told 'I have eaten gendaga' (Case 17:3).

> 'Personally, I never thought of 'kirumi', but I was told when I went for divination that I had been cursed by in-law' (Case 26:6).

> 'I was not present when my father and mother came for divination... I do not know what is kibitana, but my parents know what it is' (Case 23:2).

> 'I do not know if it was urogi or not: I cannot explain what is urogi' (Case 20:2).

Even though the full meaning of these labels (gendaga, kirumi, kibitana, urogi) is unknown to the patient, the minimum explanation attached to them allows her to understand the underground, invisible reason of her problem and offers an indication about the type of treatment to seek. This is the next step: a mugao will be sought, sometimes according to the indication of the muringia, but most frequently freely chosen by the patient himself, as in the case of Kimbu.

> 'Aringia do not tell a person to go to a particular mugao: a person knows that a particular mugao performs this treatment I have been told (by the muringia)' (Case 13:4).

If these labels that are the result of divination are really unknown to the lay people, why should they follow the muringia's interpretation and suggestions? These labels are esoteric but not arbitrary: their limited range of choice by the muringia suggest that they are not an individual oddity but the cultural product of a collective heritage. A 'representation collective' in Durkheimian terms (Durkheim,1898), the persuasive power of which is due to its being external to the individual consciousness. Once accepted as this, the question is: to what extent is today's lay ignorance of these 'representations' the result of a traditional ignorance or the outcome of a process of deculturation? If the divinatory session nowadays represents the only means of informal inculturation that is left regarding these labels, why cannot we imagine a time in the past when these labels were taught as a full part of the formal process of inculturation during the circumcision period? Some people I interviewed seems to suggest this:

> 'People of my nthuke (age-group) know about these things of Ugao: they know them through divination' (Case 25:3).

> 'The women of our nthuke do not know the reasons for kibitana and urogi' (Case 27:3).

According to my informants, a certain level of knowledge of Ugao 'medical' concepts was traditionally maintained among Tharaka lay people through both informal and formal instruction. The acquisition of this traditional knowledge was in fact done informally by adult Tharaka on a father-to-son or mother-to-daughter basis: through this process, the most commonly used

herbs and the meaning of the labels used by the agao to define and treat certain problems were transmitted. Thus, such knowledge was exchanged freely among peers. But it was immediately after initiation that the most intensive and comprehensive teaching of medical knowledge and herbal skills took place. For the male initiates (nthaka), this was collectively done by the elders in the gaaru, the common home of the warriors. Female inititates (matiga), instead, received their formal instruction in their individual houses, where they were secluded alone, by their initiation mother (mugwatani). Their training also included education regarding sexual behaviour, family spacing, pregnancy and childbirth.

My informants were agreed that after learning in the initiation period the concepts and behaviour necessary for healthy living, both male and female young adults were expected to have acquired the proper knowledge to cope in any episode of illness. And it was after this period that male Tharaka who wanted to become experts began their training to receive specialized instruction as agao.

Nowadays, this formal process of inculturation is over: school education in the Western style has taken its place. Initiation has remained purely centered around the sexual operation of circumcision and the ceremony accompanying it. This means that most of the traditional knowledge which was transmitted in the past during this period is no longer taken over by the young. This is what the female informants above meant when they spoke in term of their nthuke: their age-group did not

receive the instruction previous age-groups received in the past. This implies that the only way left to learn this knowledge is on informal occasions, such as a divinatory session with the muringia, or during conversations with relatives or neighbours. In this circumstances a reduction and a fragmentation of the traditional knowledge is inevitable. And this can probably explain the ignorance manifested by most of my informants, especially young adults, with no significant difference between the two villages I studied.

To sum up, the dual classification of illnesses in terms of a dichotomy between a natural, physical level and a magical, supernatural level already found in many research works on Africa (Fosu, 1971; Van Etten, 1976; Buck et al. 1970) and previously labeled by Foster as 'folk dichotomy' (Foster, 1958), and by Evans-Pritchard in terms of the distinction between a 'how' and a 'why' level (1937), is confirmed even in Tharaka. What Tharaka people's behaviour shows is that this dichotomy is not exclusive: both levels can in fact be present successively in the same illness episode, as most of the above cases show. This dynamic processual phenomenon needs to be explained in terms of the notion of a 'multiple causality' (4): the two etiological levels may be present in any one illness while the symptoms remain unchanged but the kind of factors thought to be contributing to their causation may be seen to increase as the problem progresses or does not resolve. This 'unified' view of illness, as Fabrega terms it (1974), has also been shown to exist among the Mandari (Buxton,1973), Nyakyusa (Wilson, 1963), Zulu (Ngubane,1977) and Gusii (Le Vine,1966)in

Africa. It can be elicited both from emic explanations I have collected and by analyzing the sequence of therapeutic choices in each of the episodes I have summarized. Particularly in the latter ones, we can trace a clearly defined sequence in the behaviour described. Tharaka people usually begin with a 'natural' explanation of illness which brings them to seek help of an empirical nature: the choice, here, is generally among self-help herbal treatment, shop-bought drugs or modern health facilities. If this primary classification and treatment is not sufficient, Tharaka will then move onto the second etiological and therapeutic level,one involving non-natural agents and ritual therapy by healers. In this sense it can be argued that Tharaka interpret illness as a dynamic and processual occurence, with a developmental element within it related to the possibility of a multiple causality.

'I also think that the problem is caused by evil persons who bewitched me. If it were a disease, it could have been healed within the time that I was attending the hospital' (Case 2:4).

'I am trying both, mugao and doctor, to see who can be of help. If it is urogi, the mugao will help; if it is a disease, the doctor will help' (Case 5:5).

'Some diseases cannot be treated by agao: there are diseases of the hospital and of the mugao. The diseases for agao are treated with mithega' (Case 11:3).

'If it was only kibitana, it is treated by the mugao. The doctor does not know such things.' (Case 13:7).

'Before going to the agao I have gone to several hospitals until it was impossible...In spite of the treatment, I never felt better. I was told there was no disease...in all these hospitals my problem was not diagnosed. I do not know why the doctors were unable to know my disease... I know the mugao can give people who had gone to the hospital without ever being cured medicine' (Case 18:2).

The problem, as we have seen, is that when we move from the primary, 'visible' level, to this secondary, 'invisible' level of explanation and action, lay people's knowledge is not enough. They fully recognize that this secondary level is out of their control, since they know little if anything about it. It clearly implies an esoteric knowledge held by certain types of specialists, namely aringia and agao. This means that Tharaka recognize the existence of a specific 'sphere of intervention' as part of their unified view of illness. The esoteric knowledge and technicalities held by aringia and agao, in fact, do not constitute an alternative view of illness: they simply complement lay knowledge at a different level. We can thus argue that, behind the apparently random behaviour described, there is a unitary view of illness shared by both common people and specialists. This situation is therefore somewhat different from that of a stratified cultural system such as that reported for some Asian societies where quite different professional and lay views of illness exist in a single society (Leslie, 1976; Kleinman, 1980).

The specific sphere of intervention of the agao is symbolized, in people's mind, by two things: the ngoci (horns) and the muthega (magical medicine). The horns are the primary instruments symbolizing the mugao's ritual activity, since they contain the muthega and are used during the treatment. A mugao without horns would not be a mugao: therefore, their possession and knowledge of their use publicly shows the role played by their owner. As Nkima says: 'I do not know anything about the Ugao because I have no horns' (Case 19:3). The muthega is the

magical medicine prepared by the mugao using herbs, roots, and parts of the goat (blood and the contents of the rumen) whose effectiveness is believed to lie not in its empirical components but in the mugao's power of blessing it: 'I am not a mugao because I do not know how to put a spell ('kuthiurura') on mithega' (Case 6:3) says Kiguara, an old woman who knows a lot of herbal medicines (5). This suggests that Tharaka people make a clear-cut distinction between empirical medicines (which they term as 'ndagwa') and magical medicine (called 'muthega'). The first category includes all traditional herbalists' concoctions; but also, by assimilation, modern drugs. These, in fact, are believed to act empirically and at the same 'natural' level as the herbs; and this why, nowadays, they are a full part of what traditionally was the first therapeutic choice represented by herbalism. Drugs are usually distinguished by people on the basis of their colour; and they are classified in terms of power and efficacy according to the way they are administered. Tablets are believed to be less effective than injections: the latter, in fact, 'enter directly in the blood' as many people say.

> 'An injection treats diarrhoea better than tablets: an injection is more powerful than tablets' (Case 27:2).

The generalized substitution of traditional herbal practice at the lay level by modern drugs (either from shops or from health care facilities) can be considered from two points of view. From the first point, it shows a malleable, open readiness to adopt new ways of coping with illness when these ways have been seen to be more effective. On the other hand, this can as well be considered as the result of the deculturative process due

to the loss of the traditional medical knowledge transmitted during initiation (as we have seen above). In any case, these new practices have been recorded as used within the same traditional cognitive framework and with the same traditional attitudes. Changing behaviour does not automatically produce changes in attitudes, norms, beliefs and values. This well-known phenomenon was described by Foster and Anderson in terms of 'reconciliation' of indigenous beliefs and scientific practices: '...But the evidence indicates that it is the perception of the desired results - recovery or improvement - and not the understanding of Western disease theory that leads traditional people to modern medicine' (1978:250-1). Changes in overt behaviour do not automatically mean changes in the belief system of a given culture. As Foster and Anderson again puts it: 'Therefore to abandon traditional health beliefs is a far greater step than to accept a new mode of therapy; it means relinquishing a major support to a group's sense of identity and view of itself' (cit:251).

The cognitive dichotomy and the 'double behaviour' it produces can thus be considered the culturally syncretic outcome of a pragmatic attitude whose real concern is the perceived efficacy of any therapeutic action. Consequently, this empirical, pragmatic behaviour cannot be considered in contrast with the traditional belief system: on the contrary, it accomodates it, to the extent that the 'new' is subsumed into the 'old'. Many scholars believed that the new - sooner or later - would have dismantled the old. Implicit in this belief was an underlying

evolutionistic approach. The Tharaka case shows that this does not necessarily happen: even though a span of more than three decades is still a not very long period of acculturation, we can say that Tharaka people have reacted with behavioural pragmatism and attachment to their cultural tradition at the same time. This 'double mouvement' has made it for them possible to make new, exogenous therapeutic choices which the old cognitive system was able to accomodate within its framework.

A comparison between the two research sites does not show any meaningful difference in this respect: in spite of the process of acculturation and modernization in Kibuka being more advanced than in Kariekajeru, the health-seeking behaviour of people did not differ significantly. Both young and elders, male and female, educated and illiterate people share the same cognitive approach to illness episodes. A particularly meaningful instance is the case of the fourteen-year-old school boy Kanyoro living in Kibuka, who showed how deeply rooted was his conviction that his problem needed to be treated by a mugao to the extent of threatening to stone his mother when she wants to take him to the hospital:

> 'Then my mother decided to take me to the hospital. But on the way, when we arrived in Mitunguu,I refused to go there: I picked up stones with the intention of beating her up because she wanted to take me to the hospital and not to the mugao.... I wanted to go to a mugao because I felt that, not unless I went to a mugao, I could not be better.A mugao is the only one who could treat me well to finish the dizziness. Even now, if I feel sick, I go to the mugao Gichugu for treatment' (Case 4:3-4).

In the words of this boy there is a clearly expressed need that only the mugao's intervention can satisfy. This is probably

the reason for the cultural persistence of the double level of etiology and the double sphere of intervention it underpins: it satisfies a need which the 'natural' level alone could not fill. If a medical system has two separated but interrelated functions, as Kleinman states, namely control of the sickness and provision of meaning for the individual's experience of it (Kleinman, 1974), then probably the second level of etiology and the mugao's therapy it legitimates, can adequately satisfy this function in Tharaka culture. If this is the case, we can imagine it will continue even in the future, in spite of any further modernization process.

The above does not mean that there are not cases which represent an exception or a variant to the proposed model: but they can be explained in terms of factors other than cognitive ones. For example, in the case of Kaindi living in Kibuka, it is the religion and its moral precepts that exert a significant influence on her behaviour:

> 'I have never gone to a mugao: I cannot go to a mugao because even my parents never went to a mugao. They were Christians, and I also became a Christian. Even the time my parents belonged to P.C.E.A. (Presbyterian Church of East Africa), people were not encouraged to go to agao' (Case 7:2).

Even in the case of Gakunyi, living in Kariekajeru, her belonging to a Christian religious denomination exerts a significant influence on behaviour:

> 'I never went to a mugao because my christian faith (Pentecostal) does not allow to do it. I said: 'I will not live to do what my forefathers were doing. I will not go to a mugao because there is no reason'' (Case 22:2).

However, this religious constraint does not seem to significantly modify the common cognitive model: it simply

transforms an openly accepted behaviour into a secret, prohibited one. Most of my informants, in fact, told me that the followers of various Christian denominations usually do not stop going to agao: but they do so only at night. This represents one of the main problems these churches face, as their pastors told me (6).

Another source of behavioural variation can be the individual management of illness: in fact, to the extent that a kin-based 'therapy managing group' (Janzen, 1978) such as that in the case of the twenty-five years old Nyamu (Case 9) or of the fifty-five years old Kagondu (Case 21) continue to exercise its influence, any cultural variation is less probable.

> 'Relatives advised me to go to a muringia. The brothers of my family met to decide what had to be done to save me. My brothers-in-law and my brothers met to discuss where to take me. I was very sick then. They had met three times: firstly, they decided to send me to the dispensary; secondly,they made arrangements to bring Marigu (mugao) for me. The third time is when they decided to call Nkoru (another mugao) for me' (Case 21:3).

The canonical sequence of choice is more probably respected when the social group - either relatives or neighbours - exercises its cultural pressure on the sick person. Nowadays, especially in the more acculturated areas such as Kibuka, the neighbours seem to have taken the place, in most cases, of the traditionally kin-based group in advising the afflicted person on the right thing to do. Even though this is still very rarely the result of individual choice even in this area, there are sometimes cases of variation due to individual idiosyncrasy: such as in the case of Muthoni, the seventeen-year-old Secondary school student who prefers to consult a kiroria (prophet) for her foot problem, after uselessly visiting many hospitals (Case 15).

There is a further set of factors related to health care which Tharaka people mention as a source of choice variation: the real, concrete availability of health care services is the one most frequently mentioned. The range of health care choices in Tharaka is still limited, especially in the most isolated areas such as Kariekajeru. People here know that, apart from home remedies (herbal concoctions) and the agao, the closest modern health care facilities (the Catholic dispensary in Materi or the Government Health Centre in Chiakariga) require at least a day's round trip. The next nearest hospitals (Nkubu, Ishiara and Chogoria) need at least one night spent away from home. This necessarily implies a series of costs - for fees, transport, meals and accomodation - which are not always affordable:

> 'My desire is to go for examination to a hospital, but my husband is too poor to afford the fee' (Case 1:3).
>
> 'I went to Nkubu hospital, I was treated and I got all right. I was told to go back for more treatment but I had no money (Case 3:1).
>
> 'I do not have any money to go to the dispensary for an injection: otherwise, I could go there and try' (Case 12:3).

The scarce availability of modern health care services and the unaffordable expense they impose, represent serious constraints on health care choices in Tharaka. But even when people decide to struggle for them, the degree of satisfaction is reduced by the poor level of communication:

> 'I was told nothing in Nkubu hospital when I went, I was just treated and told to go back again. The last time I went, I was given medicines: I did not know how they were. We were given two of us (with the husband) and when we took them we had diarrhoea.... When we finished the medicine, we went back to the hospital but we never saw the doctor, we were told that he was absent. I missed money to go back to

the hospital' (Case 25:2).

> 'I was uncontented with the hospital treatment. I went to Chogoria hospital and I was told that the doctor was not present. I went to Meru hospital and I was told that the doctors were absent. When I went to Ishiara hospital I was "washed", but I was never told the reason why. I was only left like that, without knowing the reason why' (Case 2:3).

All these factors makes the relationship of Tharaka people with modern health care facilities diffcult, so that they become sources of possible choice variation in the sense that they discourage their utilization. This seems particularly true for areas such as Kariekajeru, where geographical, economical and cultural 'distance' (7) from modern biomedicine is still a real problem. However, in many cases it is the 'quest for result' that inspires people's pilgrimage from one facility to another one, from one type of therapist to another one. A quest that is not simply fortuitous; it is often based on trial and error, seeking to compare the outcomes obtained whether with traditional or with modern health care:

> 'I went to two aringia (diviners) so that I could compare the results, to see if the results would be the same. They both told me it was urogi' (Case 16:3).

> 'I was changing hospitals like these (Chogoria, Meru and Nkubu) because I was trying to see where I could be treated and recover more easily. People often tell me: 'this is better', or 'that is better' (Case 10:4).

The quest for results also produces a sort of 'pendularism', or circular movement between the two levels of etiology and treatment in an obstinate attempt to get the wanted result:

> 'I wanted to go to these aringia (diviners) so that they could also tell me what is the problem, the reason why I am not recovering...if I am treated and it is impossible (the recovery), then I shall return to the hospital again' (Case 13:3).

This endless pilgrimage can only be interrupted by a feeling of total dissatisfaction as in chronic cases; such a case was that of Ciampui, who unsuccessfully went many times to both agao and modern health facilities for her infertility problem:

> 'I say that if one is contented, one must possess what was being pursued. When one has not possessed what is pursued, one cannot feel contented. There is no reason to be contented since one has not found what he wanted' (Case 2:3).

3.3 Cognitive Structure of Illness and Intra-cultural Variation

The above emic interpretations supplied by Tharaka people need now to be systematized into a more comprehensive approach which could be used to analyze adequately their health-seeking behaviour and the role played in it by lay knowledge. Sociological, anthropological and epidemiological research on the management of illness in Africa and in other developing countries has produced over the last two decades a considerable amount of findings of both theoretical and practical relevance. On the basis of the literature reviews by Kroger (1983) and Slikkerveer (1990), we can identify two main approaches to the problem:

a) Determinant models, which focus on a set of explanatory variables or 'determinants' of health care utilization (8);

b) Pathway models, which concetrate on various steps or phases of decision-making in the process of illness behaviour (9).

With regard to these approaches, I wish to stress some points whose importance is, I think, paramount for our topic.

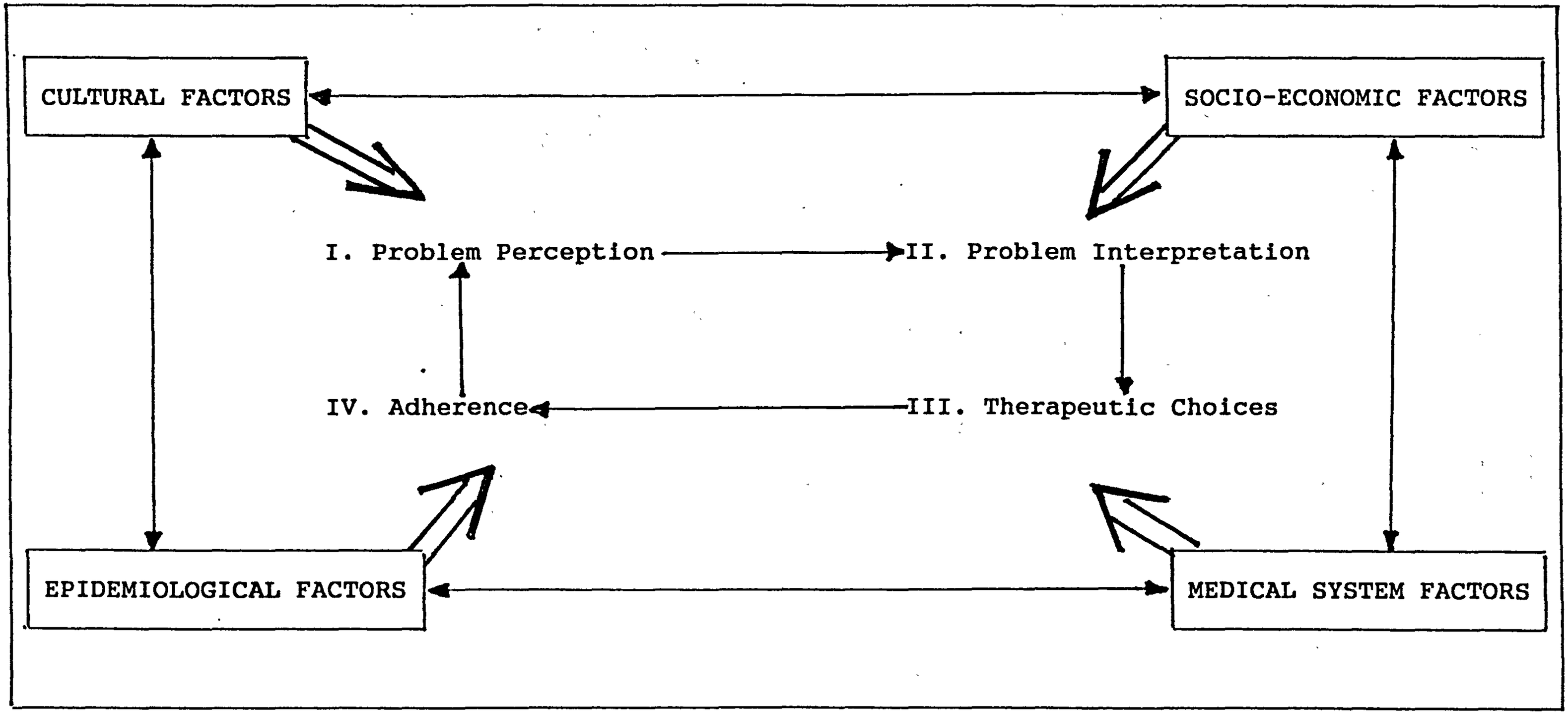
Firstly, the multifactorial basis of the decision-making process leading to what is defined as 'health seeking behaviour' makes plain the limitations of any approach which takes into account the influence of single factors only (mostly the pathway models). Secondly, since the nature of the relationship between these factors, and between them and the decision-making process, is dynamic (reversible) and systemic (multidirectional), any causal model based on an unidirectional, linear correlation between a group of factors (predisposing, enabling, and system factors) considered as independent variables and the illness behaviour (reduced to treatment choice) considered as a dependent variable (determinant models), is too limiting, since it overlooks both the causal links among the different independent variables, and the links between these and the various components of illness behaviour and this is not limited just to therapeutic choice.

On the basis of the above and from the analysis of my research findings, I argue instead for the need of a more comprehensive, holistic approach to the health-seeking process, an approach which could overcome the limitations of both models. This can be accomplished by building an eclectic model based on the integration of the two approaches (particularly Chrisman's and Slikkerveer's models) and on a multifactorial and multidirectional model of causality. The model I propose (fig.3.1) is based on four blocks of factors: <u>cultural</u> (norms, beliefs, knowledge, attitudes, values,etc.) and <u>socio-economic</u> factors (age, sex, education, ethnic group, household composition and size, religion, occupation, status, social network) are

related to the sick person and his social relationships, whereas epidemiological factors are related to disease considered as a biological entity in its host environment ('objective' ways of presentation of the disease, its nature, severity, prevalence and duration), and plural medical system factors are related to the characteristics of this sub-system and its role in the social system as a whole (range of therapeutic options, type of practioners, accessibility, affordability, acceptability and attractiveness of different choices of health care). These four groups of factors are all interacting reciprocally among themselves and can variously influence the different stages or components of health-seeking behaviour. The nature of the decision-making process of the latter is divided into four steps: problem perception (symptoms recognition or ignorance), problem definition and interpretation (labeling, causation, various dimensions of attribution, decision to enter or not the sick role), therapeutic choices (actions undertaken to cope with the illness occurence, decision to enter or not the patient role) and adherence (actions upon treatment advice).

The four stages of the decision-making process producing health seeking behaviour are reciprocally related in a circular model of causality; and each stage can be variously influenced by one or more of the four groups of factors. The study of the latter can explain which factors are more influential in the process of choice; the study of the actual health-seeking behaviour can explain how practically the choice is produced. A

Fig.31 A MULTIFACTORIAL MODEL OF THE HEALTH-SEEKING PROCESS



useful element, in this respect, could be the notion of 'judgemental heuristics' (Mathews,1982) used by the patient to simplify the decision-making, eliminating the need for more rationalistic calculations. If we do not want to reduce the patient to a sort of homo economicus always engaged in calculating the cost-benefit balance of his choices, we have to consider him as a social actor who actively interacts with the whole range of factors examined in decision-making, variously combining them in his 'pragmatic' behaviour. This will be the outcome of a chain of interacting factors (the four blocks) variously influencing a chain of reversible decisions (the four steps of the health seeking process).

This perspective of the social actor (Fabrega, 1974) implies an understanding of the mediation between the clinical fact of the disease and the subjective experience of illness. We know from the literature that, while the clinical characteristics of a disease are culturally invariant, the phenomenological experience of illness is highly variable (Kleinman, 1980; Mechanic, 1978; Eisenberg, 1977; Obeyesekere, 1978). The influence of culture (and, particularly, of knowledge) on subjective experience of illness, however, has not been elaborated adequately (10); and even the interaction between cultural/non-cultural factors has often been overlooked. I wish to end my discussion here by trying to resolve these two problems on the basis of the multifactorial model of health seeking behaviour I have proposed.

Starting with the emic interpretations offered by Tharaka people and analyzed in paragraph 3.2, we can test the actual

capability of the proposed model in eliciting the cultural and non-cultural factors that co-determine the behavioural choices. We first need to single out the four steps of the health seeking process, the chain of decision-making. The first stage, 'problem perception', includes the decision to pay attention to or ignore the symptoms. In Tharaka this implies, as we have seen, a certain degree of pain (murimo, illness = pain) and a vocabulary of distress based on a certain knowledge of the body (ethno-anatomy and ethno-physiology). Both produce a filtering of perceptual inputs by the Tharaka individual, who actively selects sensory information received and decides which should be considered as relevant symptoms and attended as such. We could imagine that this first decision occurs in a random fashion but the general agreement found among my informants shows that it is more probably directed by something like a set of 'templates' which underwrite this decision in people's minds. This is to say that there is probably a mental, cognitive process that takes place, and this process is culturally influenced. Tharaka culture, in fact, determines whether certain bodily states are to be considered normal or abnormal, even offering a label to denote them. This culturally influenced mental process has been defined as a 'first order categorization' (Angel and Thoits,1987:474), by means of which it is operated as 'a mapping of unmediated physical and emotional stimuli into culturaly relative and learned intepretative categories concerning one's state of health or illness' (cit:475). In the authors'intention, this 'first-order information processing' includes the judgment of

normality/abnormality: my Tharaka field data show that this implies what we could term a 'threshold of tolerance' determined by pain perception. In Tharaka this threshold is very high; in other cultures (ours included!) this cannot be the case. I can argue that, in Tharaka, the variation in the first-order categorization can be influenced by other non-cultural factors: such as the epidemiological state of a certain population (and the kind of disease prevalence) or the socio-economic factors (social status, religion, education). However, it remains mainly the result of cultural processes, especially the inculturation process through which the reference group influences categorizations of experienced states as normal or abnormal. The society to which the individual belongs, in fact, establishes cultural standards for the obtrusiveness and persistence of any particular physical or emotional condition: these culturally defined standards will determine the individual's decision to attend to or ignore them.

The second step is 'problem definition and interpretation': this includes the illness labeling process, an explanation about it, and a decision concerning whether to enter the sick role or not. Even this set of decisions necessary implies a 'second-order categorization' (Angel and Thoits, 1987:477) in terms of a number of dimensions, such as seriousness, causation, chronicity, responsibility and prognosis. In this way the individuals cognitively order their interpretations of internal states in a culturally structured fashion: 'While each culture structured their conceptions of diseases in terms of specific cognitive dimensions, these dimensions differed significantly between

cultures' (cit:479). According to my data, in Tharaka culture the two most important dimensions used for labeling and interpreting the problem are probably seriousness and chronicity. As we have seen, in fact the more a problem is serious and lasts for a long period, the more people will start thinking of it as implying an underlying, invisible level of causation needing a muringia to be uncovered. This will produce a labeling of a certain type, whose meaning is fully known only by specialists (agao). The judgment on the nature and etiology of an illness is fundamental for problem interpretation. Even the consequences in terms of being unable to fulfil certain functions (working, walking, etc.) is an importantly evaluated dimension of problem interpretation. Moreover, all the three dimensions of seriousness, chronicity and functional consequences determine the decision whether to enter or not the sick role: as we have seen, this in Tharaka implies a serious, mostly chronic and highly impairing problem.

Therefore, in this second order categorization concerning problem interpretation the influence of cultural factors is determining in establishing which dimensions are to be evaluated and in which way; and what knowledge is needed to interpret the problem. For a first level problem, naturally caused, lay knowledge as well as biomedical knowledge are considered appropriate; for a second level problem, non-naturally caused, the specialist knowledge of a Tharaka professional (mugao, muringia) is needed. Non-cultural factors influencing this second level of categorization in Tharaka are mainly of social nature:

such as the 'expression norms' (Hochschild, 1979), which guide the disclosure and display of feeling to others (particularly for male adults); education (scientific knowledge) and, particularly, the influence exerted through the social management of an illness episode by relatives or neighbours. A certain degree of influence is also experienced in the contact with health care resources, whether modern or traditional, and by the way the problem is interpreted by professionals there.

The third step is 'therapeutic choices', including the way symptoms are acted upon, whether help will be sought and from whom, and the consequential decision to enter or not the patient role (11). This is a key step for our subject: in Tharaka, as in many other African societies, it is based on the cognitive dichotomization of illnesses into those treatable by indigenous and Western or herbal therapy respectively. This 'third-order categorization' (12) creates de facto two categories, two separate spheres of intervention: one dealing with the first, natural plane of causation is the province of both Western biomedicine and indigenous herbalism; and one dealing with the second, non-natural plane of causation is the province of indigenous Ugao. The first sphere implies using ndagwa, materia medica; the second sphere involves muthega, magical medicine proper of the agao. I wish to call these two speres of interventions 'jurisdictions' in order to stress their having the character of 'legal' authority, fully recognized and legitimized right to carry out a task within the boundaries of a certain territory (12). What appears particularly interesting in this Tharaka dichotomization is that biomedicine is not perceived as

having a separate sphere of intervention: on the contrary, it has been slotted into an already existing scheme. This suggests to us two consequences: firstly, biomedicine has never been considered as competitive with the indigenous Ugao, since they are considered to work at different levels, in two separate (and complementary) spheres of interventions; secondly, the coming of biomedicine has introduced a more powerful option for intervention in the first jurisdictional sphere, competing with the traditional ones (home herbalism, ajukia, etc.). The fact that this new option has in many instances ousted the old ones means that these were the really competitive options, to the extent that, nowadays, the other traditional options have almost been absorbed into what is termed the jurisdiction of the 'illnesses of the hospital' ('mirimo gwa chibitari').

In any case, what matters here is that in Tharaka cognitive categorization the real distinction is not between traditional and Western medicine, but that between the two spheres of interventions: the jurisdiction of the ndagwa and the jurisdiction of the muthega. Therefore, a single 'hierarchy' of therapeutic options, and not parallel systems of medicine, exists (14). The fact that, at the cognitive level, the practices of biomedicine have been accomodated in the traditional dichotomous scheme shows that a syncretization process has taken place without necessarily altering the basic cognitive structure.

However, this dichotomization is not always maintained in practice, since other factors, apart from cultural ones, exert their influence on this third step of health-seeking behaviour:

namely, those regarding the socio-economic condition of the sick person (economic status, religion, education) and the plural medical system (availability and affordability of actual therapeutic options, their acceptability and attractiveness). These other factors can explain why the dichotomization of medical conditions at the cognitive level is not always mantained when it comes to practical behaviour: this even suggests that the dichotomous categorization is not rigid, but is flexible, expanding or contracting what can enter within the boundaries of each category.

The last step in the health-seeking process is 'adherence': the degree to which the sick person acts upon treatment advice (15). This decision depends on an important judgement: how effective is the treatment/advice received considered? As we have seen, the 'quest for result' is almost an obsession in the behaviour of the Tharaka patients: their sorrowful pilgrimage from one health care resource to another one reveals this. The perceived efficacy of the treatment received becomes an important condition of adherence to the treatment/advice received. This represents what we could term a 'fourth-order categorization', implying an evaluation of the therapeutic effectiveness of the treatment received. We can suppose that this cognitive process is culturally influenced, even if we do not know how yet; and that even other factors related to the medical system (type of practitioner, patient/practitioner communication, power of persuasion of the latter, etc.) exert a significant influence on the decision to adhere to a therapy or not. These factors can also produce a restructuring process of the patient's cognitions

in order to bring them to conform more strictly with the practioner's ones (either traditional or modern). This is what has been termed an 'altered second-order categorization' (Angel and Thoits,cit:474): the contact with experts can convince the patient to re-examine his problem from the expert's point of view, so that the therapeutic process can proceed. This can happen either in the contact of the Tharaka patient with a muringia/mugao, or with a modern practitioner.

In summary then, we can wonder whether the model I proposed can really work and is consistent with my field data. I think the above analysis suggests it does, even though on three conditions:

a) That we hypothesize the existence of a 'cognitive structure of illness' (Kleinman,1974; Angel and Thoits, 1987) behind the decision-making process regarding health seeking, through which bodily/mental experience of illness is filtered and defined and the necessary decisions concerning interpretative and behavioural options are produced (16). This cognitive structure is not really a 'frame' or a 'schema', since it is not rigidly defined, but is composed of a series of cognitive categorizations (probably of four orders) concerning problem definition and interpretation, therapeutic choices and adherence to them (17). The existence of such structured cognitive categorizations of illness are revealed empirically as lexical categories reflecting phenomenological groupings of illnesses and different spheres of proper intervention (fig.3.2).

b) That this cognitive structure being considered as learned and culturally-specific and malleable (Angel and Thoits, 1987:475). Such cognitive structures, composed of collective representations transmitted as a result of a group's system of inculturation, could be usefully tested and compared cross-culturally. This could allow us to understand better the influence of culture on cognitive processes through which lay persons come to define themselves as ill and to select curative options. I agree with Angel's and Thoit's thesis that 'individuals inherit from their cultures structured vocabularies of health and illness which limit the possibilities for the interpretations of physical and psychological states and structure help-seeking options. As with other aspects of culture, these vocabularies are "overlearned" such that they acquire the status of unquestioned objective reality' (cit:473).

c) That, as the same authors state, 'although cognitive categorizations and vocabularies of distress influence the interpretative and behavioural options available to an individual in response to physical or emotional change, they do not rigidly dictate a specific set of responses to every such change. Rather, they comprise predispositions which interacts with situational factors to determine the outcome of any particular illness episode' (cit:482). The evidence from my Tharaka field data indicates that the response to any episode of illness depends upon a number of other factors (socio-economic, epidemiological and the plural medical system) which I have tried to synthesize in my multifactorial model. This shows that the culturally

Fig.3.2 The cognitive structure of illness

HEALTH-SEEKING BEHAVIOUR	COGNITIVE STRUCTURE
I. <u>Problem Perception</u> Attend to or Ignore the Symptoms	<u>First-order Categorizations</u>: - Threshold of Tolerance (Normal vs Abnormal) - Vocabulary of distress
II. <u>Problem Interpretation</u> Enter or not the Sick Role	<u>Second-order Categorizations</u>: - Illness Labeling and Classification - Dimensions of Interpretation (Seriousness, Duration,etc.)
III. <u>Therapeutic Choices</u> Acting on Symptoms Enter or not the Patient Role	<u>Third-order Categorizations</u>: - Spheres of Intervention (Jurisdictions)
IV. <u>Adherence</u> Acting upon Treatment Advice	<u>Fourth-order Categorizations</u>: - Evaluation of Therapeutic Effectiveness - Relabeling (Altered Second-order Categorizations)

learned cognitive categories interact with idiosyncratic aspects that are the result of individual experience. The high degree of pragmatism shown by Tharaka people in their way of choosing therapy is in contrast with any deterministic consideration of it (18): instead, it suggests a certain degree of intra-cultural variation in health-seeking behaviour due to the influence exerted by a series of non-cultural factors on individual

experience.

To conclude: on the basis of the above, if we return to our starting point - namely the role of lay knowledge in health-seeking behaviour - we can consider such knowledge as fully part of the impact which culture exercises on the cognitive processes which determine the interpretation of psychological and physiological events that lead to the therapeutic options choices made by people. This in Tharaka means, as we have seen, a dynamic, unitary view of illness based on a concept of multiple causality working at two different levels. The two spheres of interventions regarding therapeutic options we have called 'jurisdictions' are grounded on these two etiological levels. Therefore, we can consider such jurisdictions as rooted in the 'cognitive structure of illness' shaped by Tharaka culture and in the health-seeking behaviour this determines, acting as a go-between the different sets of factors. If we want to go beyond this, now that we have examined lay Tharaka knowledge and its relationship with modern biomedicine at the first level, we need to study the professional knowledge of Ugao at the second level: this means understanding how such a type of esoteric knowledge is produced, acquired and applied by its carriers - the agao - as a group of experts in the ancient Tharaka art of 'medicine'.

FOOTNOTES TO CHAPTER 3

1) If we observe data reported in the survey on Tharaka modern health care facilities' utilization (Appendix B), we can see that there is a prevalence of attendance (where children are the majority) during the long rainy season of nthano (March-June) and the short dry season of muratho (December-March). Since most of my field work with the people was done during the long dry season of thano (from mid-June to mid-October), we can argue a seasonal decrease of health problems during such period especially for children.

2) The morbidity prevalence evidenced by the utilization survey (Appendix B) shows that malaria is the commonest disease in Tharaka (49.3%).

3) The classic statement of the 'sick role' has been developed by Parsons (1951:436-7) and restated succinctly by Segall (1976) in terms of an interrelated set of two rights (absolved from responsibility and exempt from 'normal' social roles) and two obligations (to get well and to cooperate with professionals). A number of writers have noted significant variability in the normative and situational aspects of the sick role (Gordon,1966; Twaddle, 1969): such variability can be the result of differences in normative expectations in different cultures.

4) I am in debt to David Nyamwaya for the notion of 'multiple causality' as several causal agents present in any single illness episode and belonging to different levels of causation. However, Nyamwaya's distinction of three planes of causation (the biological, interpersonal and spiritual) in my opinion introduces a series of categories which are substantially extraneous to African cultures (Nyamwaya,1977) where the distinction between a 'natural' and an 'unnatural' level is usually present.

5) It is interesting that the verb 'kuthiurura' has the same stem '-thiurura' as the name 'nthiurura', dizziness: the symbolic implication seems to be that the mugao's performance 'twists', enchantes the herbal medicine in order to make it effective.

6) The problems the legimitation of traditional medicine entails in Tharaka and in other modern African societies as well are dealt with at greater length in Chapter 10.

7) For a critical opinion on the role of distance as predictor of health care utilization, see Good,1987:113-4; in particular, his concept of 'distance decay'because of behavioural factors, quality of services, sex and age appears relevant to the Tharaka situation.

8) This approach, mainly based on quantitative empirical data and large population-based surveys, has been preferred in sociological and epidemiological studies.It usually classifies a number of blocks of variables of different kind, thus estimating their different value in determining treatment choices. For example, Unschuld (1975:303-312) points out economic barriers, communication gaps and structural differences as being important in health care utilization. Yet, the dominant model (with its variants) in this approach is undoubtely the modified version of the behaviouristic model of Andersen (1968) proposed by Kohn and White and their WHO/International Collaborative Study on Health Care (1976). This widely used comparative model is based on three blocks of variables: predisposing factors (demographic, socio-cultural and economics characteristics); enabling factors (accessibility and costs of health care); and health services system factors (structure of the health care system and its linkage to a country's socio-political macro-system). A slightly modified version of this model is proposed by Kroeger (1983), who adds a fourth block of variables: the characteristics of the disorder and their perception, including type of disease (acute/chronic), its severity (trivial/severe), its aetiological explanations, and the expected benefit of treatment (satisfaction/ dissatisfaction). A further slightly modified version of this approach is proposed by Slikkerveer (1990) in his research in the Eastern highlands of Ethiopia. He stresses the importance of a multivariate pattern of relationship among five blocks of variables, three of which are at the individual level (predisposing, enabling and perceived morbidity factors), and two at the system level (plural medical system and health care utilization factors).
In my opinion, this approach suffers from some fundamental limitations which Kroeger has already pointed out (1983:156): mainly, that it is a complicated way of compiling data and it fails to take the influence of social networks sufficiently into account. I wish to add a further criticism: particularly in the Kroeger (1983) and Slikkerveer (1990) versions of the model, the perceived morbidity factors are not clearly defined as to their subjective or objective nature. Since they are referred to as 'characteristics of the disorder', it seems that the objective qualities should prevail on the subjective ones. Moreover,in spite of any stated intention, this approach fundamentally maintains a unidirectional cause/effect linkage, thus using a simple model of linear causality. The trivial or tautologic results of most studies which used this approach to analyze samples from relatively large population groups can probably be explained on the basis of the shortcomings of the model.

9) This second approach, termed as 'pathway model' or 'phase diagrams' (Slikkerveer,1990:51), is mostly based on qualitative research about a limited number of cases of illness, which makes it more suitable for anthropological research. There are different variants of this model, all

describing the various stages or components of the process of health-seeking behaviour, with a particular attention on cognitive elements which produce the therapeutic (and other) choices by the sick person.
Suchman (1965) is the first to establish the foundations of a process-based approach to illness behaviour by describing it as a logical sequence of steps.His five-stages model includes: 1) symptom experience; 2) assumption of the sick role; 3) medical care contact; 4) dependent patient role; 5) recovery and rehabilitation. The importance of Suchman's model consists in rendering illness capable of being described as a dynamic process of successive stages, each stage giving rise to specific problems which can result in a choice between various forms of alternative behaviour.
Geertsen et al. (1975) later proposed a revised version of Suchman's model, stressing the importance of ethnic background, social norms and values,past individual experiences of medical system and his attitudes concerning illness.
Fabrega (1974) proposed a model of the information processed during an illness based on a systemic approach to the person, including the biological system (chemical and physiologic processes), the social system (relationship between individuals and other persons, groups and institutions), the phenomenologic system (state of awareness and self-definition) and the memory system (attitudes towards and experiences of illness). The information available to the individual during an illness then processed in nine stages (cit.:171): 1)illness recognition and labeling; 2) illness disvalues; 3) treatment plans; 4) assessment of treatment plans; 5) treatment benefits; 6) treatment costs; 7) net benefits or utility; 8) selection of treatment plan; 9) set-up for re-cycling. As Fabrega himself recognizes, his model 'borrows heavily from economics and elementary decision theory' (cit.:175), and it is based on a series of assumptions (illness undesirability, its discrete occurence, rationality of people's choices, etc.) which makes it difficult to be applied transculturally, especially in those cultures where such assumptions cannot be taken for granted. Moreover, Fabrega's stages appear as cognitive processes which can occur simultaneously in the afflicted person's mind.
Apart from a further stage-model proposed by Igun (1979), of some interest is the component-model offered by Chrisman in his approach to what he terms the 'natural history of illness' (1977:351). In his framework, the existence of predominantly social and cultural factors and their integration is schematically depicted in five major components: 1) symptom definition; 2) illness-related shifts in role behaviour; 3) lay consultation and referral; 4) treatment actions; 5) adherence. The particular interest of this model lies in the fact that the above five elements are not necessarily considered as sequential: in fact, the dynamic nature of the process of health-seeking can produce differential temporal relationships among the various components in each specific illness episode. However, in my opinion, the specific cultural or social nature of each

factor makes the model a sort of 'hybrid mix' which does not seem to fit properly the behavioural and cognitive character of the health-seeking process. Moreover, other factors of a different nature (such as socio-economic ones) are overlooked in this approach.

10) Only the ethnomedical approach, in the course of the Seventies, has focused on local etiologies and medical knowledge as important determinants of health-seeking behaviour. The work of Janzen and Bibeau in Zaire, of Warren in Ghana and Young in Ethiopia have explicated the etiologies of the local systems of indigenous medical knowledge in dualistic terms: 'natural' and 'supernatural' (Warren,1974), 'diseases of God' and 'diseases of men' (Janzen,1978), 'internalizing' and 'externalizing' systems (Young,1976), 'agent' and 'empirical' cause (Bibeau,1979).

11) The role model termed 'patient role' has evolved from a criticism of the functionalist approach proposed by Parsons:in fact, since the obligation to seek professional care is an element of Parsons'definition of the sick role, he fails to differentiate between the two roles. Subsequent scholars considered the patient role as a special case of the sick role, requiring formal medical validation (Jaco,1972; Taylor,1970): what this can mean in the plural medical system of a non-Western society is still a quite unexplored topic for anthropologists.

12) Whereas the first two-order categorizations (together with the 'altered second-order categorization) are taken from Angel and Thoits'model (1987:474), this third-order categorization and the following fourth-order categorization as well (with their respective contents) represent my contribution in an attempt to complete their model which, as the two scholars themselves state, 'focuses primarily on the earliest stages of the symptom recognition and evaluation process' (cit:466-7).

13) The indigenous vocabulary that suggested this idea of 'jurisdiction' in emic terms are explained in Chapter 7; in any case, the etic utilization of the term 'jurisdiction' here has a largely symbolic meaning, in terms of a professional authority, legitimately exercised upon a certain cultural domain. In this sense, our use of this concept here is close to that proposed by Abbott, who defines it as 'the link between a profession and its work' (1988:20).

14) The concept of a 'hierarchy of resorts', first proposed by Schwartz (1969), is used here to mean an order of categorization based on the proposed dual classification.

15) I agree with Chrisman when he prefers the term 'adherence' over 'compliance' because of the difference in power or authority the latter entails between advisor and advisee (Chrisman,1977:370); whereas the former term refers to a broader range of interactions, including those in which the

sick person and the advisor participate in an egalitarian social bond.

16)The concept of a 'cognitive structure' is used here in the sense proposed by Geertz (1973;1984).

17)In this sense, I think it is possible to agree with Young's worry about the tendency of ethnomedical studies to overlook social processes of knowledge production in favour of a structuralist view of knowledge (Young,1981:379).

18)Most published literature on the management of illness in Africa reveals an over-emphasis on the degree of uniformity in responding to illness occurence (Buxton,1973; Harwood,1970; Imperato,1977; Ngubane,1977). However, medical anthropological studies have increasingly shown that intra-cultural variation in health-seeking behaviour is not restricted to Western complex societies but it also occurs within even small, and apparently culturally homogeneous societies (Janzen,1978; VanEtten, 1976; Ademuwagun,1979).
Moreover, I argue that emotional components of the decision-making process can be considered another main source of intra-cultural variation in terms of non-rational determinants of the individual's behaviour due to his real experience (Young, 1981): in this sense, it is perhaps possible to consider the emotional components as producing a sort of 'short circuit', breaking the normal sequence of behaviour induced by the cognitive structure of illness acting at the subconscious level.

Plate 3. My master of Ugao M'Mburuki Muthia (May 1986).

Plate 4. During the apprenticeship: the hand-over of the horns (May 1986).

Plate 5. The paraphernalia contained in a mugao's kiondo (basket).

Plate 6. The mugao Ngunku prepares the muthega (medicine) according to the 'old Ugao'.

PART II

THE 'UGAO' JURISDICTION

CH. 4 BECOMING 'MUGAO'

4.1 A Preliminary Conversation

Monday, 12th May, 1986

The full meaning of the existence of what I termed a 'jurisdiction' came clear in my mind the day I was driving back home after the umpteenth meeting with the Tharaka agao: it was already almost two years since I had started working with them and I was a bit discouraged. After a good start that had seen me introduced to them, with a good relationship built with all the some fifty agao I had met, my impression nonetheless was that every time I tried to go deeper into their world I beat my head against a wall. That day, the situation had been the same: I had spent the morning with two agao, M'Mburuki and Kinyua. The first one was an old experienced mugao, who had learnt the Ugao from his father and later went to Mombasa, where he stayed for seven years and eight months, adding to his knowledge from healers of the Coast among the Atinku, Giriama and Nyamwezi people. As any other mugao who had been initiated into the powerful medicine of the Coast, M'Mburuki was very much respected in Tharaka: and his enigmatic eyes were set in a furrowed face, giving an expression of high dignity.Kinyua was much younger than him and less experienced too, though he had been taught for a short time in Kitui by a mundu mue (the Kamba equivalent of the mugao), reputed by others to be quite famous in the art of healing and witchcraft.

On that morning, M'Mburuki and Kinyua were sitting below the

usual tamarind tree at Kibuka, not far away from Kinyua's home. At a short distance a young woman was talking with an older one while keeping a boy of about ten years old. During our conversation, the two agao informed me that the two women came from Imenti, near Nkubu, and had been treated twice for Urogi,the previous day and early that morning. Now they were waiting to see whether they would recover or not; and then, if it was the case, they would repeat the treatment. I took the chance to question them about the symptoms and they answered me giving full details about them. But when I moved from symptoms to treatment, after some little information M'Mburuki firmly stopped me saying that 'we were going too deeply into the matter and into the very secrets of the Ugao'. With difficulty, I did not express my disappointment: I understood I had reached the borderline again.

When the sun had passed midday, they proposed that I visit Rukungi, another mugao who was very sick and whom they wanted to treat. I immediately accepted and we went together using my vehicle on the ruined track leading to Muthitwa, Rukungi's place. He was a middle-aged person, halfway between M'Mburuki's and Kinyua's age: I liked him because of his clearly sympathetic attitude towards the patients and the people generally, usually expressed with great generosity. Unlike many other agao, the impression he immediately made on me was of a very transparent, sincere person.

We found Rukungi sitting in front of his home: visibly emaciated, he nonetheless spoke of his recovering. We talked freely, with no specific point to the discussion: at a certain

point M'Mburuki took Rukungi aside to speak in private. When they came back, M'Mburuki started briefing me on the fact that for the Ugao they were taught they had to pay many goats and cows to be shown all the things and, on top of that, they took a muma (oath) not to reveal anything to anybody, unless for payment. Since most of their masters were dead, they were scared of being struck by their curse, in case they betrayed the oath. I understood that they had talked about my unsatisfied thirst of knowledge concerning the Ugao and that they were probably trying to bridge the gap between the muchunku (white man) and themselves. I replied that I had understood and I promised them a full answer later on.

After we had eaten some eggs that Rukungi's wife had cooked for us, I decided to give them my reply. Since I understood their problems, I asked to be taught the Ugao on payment as usual, and to be given a regular initiation to their secrets.They started discussing the issue among themselves: Kinyua, in particular, raised a question concerning my ethnic belonging but Rukungi replied that the Ugao was not exclusively the property of Tharaka people, since even they were exchanging their knowledge with other African people. When I added that since the beginning of my work in Kibuka and Karikajeru people there had considered me as a mutharaka (Tharaka person) and had given me the kitharaka (Tharaka language) name of M'Kamwara, M'Mburuki replied that seeing that in Tharaka people had only one name, they too would have referred to me in the same way.

At this point it was clear that they had accepted my offer and I started asking for an explanation on the process: first,

whether they allowed my field assistant to attend the course. They answered that usually the apprentice must bring with him a witness and the same is done by the master with a fellow mugao, so that both the witnesses can testify that only good Ugao and not bad Urogi is taught. Second, what was the role of the three agao in the process? They replied that M'mburuki would have been the master and the two others his assistants. Third, I asked them the amount I would have to pay and they answered that, traditionally, the payment was made up of seven goats, two cows, and eight gourds of beer; plus, nowadays, seven coins of 1 Kshs each, one of 50 cents, seven coins of 10 cents, one of 5 cents, and seven notes of 10 Kshs each. We agreed on a payment in cash of about 1,000 Kshs plus a goat and eight gourds of beer. The goat, they said, would be sacrificed in order to take a muma (oath). Fourth, I asked them to clarify how long the course would last: they answered that the first part (the proper teaching) would take ten to fifteen days, whereas the second part (the apprenticeship) would depend on the apprentice and his skillfulness in practicing with patients. I pointed out that, since my concern was not really towards practising the Ugao but only about knowing it, one demonstration case could be enough. A prolonged 'Oh!' seemed to relieve them, clearing some doubts that had arisen in their minds. At this point, everything was settled and we separated after some arrangements for the beginning of the course. I had the task of finding some horns of a goat and cow, since nowadays the traditional antelopes' horns are more difficult to get; Kinyua, however, would have bring

the wax to ' close' them. The trip to explore the internal world of the Ugao jurisidiction was about to start: the following is a detailed account, based on my field notes and tape-recorded material, of my initiation as a mugao. It lasted seventeen days over a period of about nine months (May 1986-January 1987).

4.2 Day I. The Oath

Monday, 19th May, 1986

The scene takes place below the tamarind tree on the hill of Kibuka: on this spot that will become familiar during my initiation, I start to be introduced to the reserved territory of the Ugao. As with any reserve, there is a gate to pass: the oath. It is the essential condition both to guarantee for those who hold the jurisdiction the good intentions of the novice and to make the novice aware of the change of status it implies. The oath is thus certainly a 'rite de passage' in the sense of Van Gennep (1909): it marks the exit from the lay world and the entrance in the sacred landscape of a jurisdiction. By creating a new brotherhood (giciaro), the oath links together the master and his novice. Consequently, it follows the structure of the 'rites de passage': the act of separation is marked by the sacrifice of the goat; the threshold stage hinges on the oath itself and the new brotherhood is confirmed by licking the goat's blood. The act of re-aggregation is achieved in the final division and communal comsumption of the goat itself. The novice can then be admitted within the previously closed boundary and share, along with the meat, the knowledge which is guarded there.

THE RITUAL SACRIFICE OF THE GOAT

M'Mburuki starts by marking himself, the other two agao and myself with iraa, the white powder of diatomite on the side of the right eye. After that, the he-goat I had brought is untied and killed by M'Mburuki with the assistance of the other two by choking. While keeping his right knee pressed firmly on the throat of the goat whose head he holds in his hands, my master explains to me that is the way of killing a goat according to the Ugao: instead of choking it completely, you have to wait until the animal utters its two final sobs. And, what is more important, it should die while lifting its tail, otherwise if the tail is down is a bad sign for Ugao and the animal is not good for curing. Moreover, the animal should be killed facing Kirinyaga (Mount Kenya), since it is believed that that is the place of Murungu (God).

SWEARING ON THE GOAT

The skin of the goat is opened along the median line of the neck and the stomach by the two assistants; after that the throat is slaughtered and M'Mburuki plunges a needle (mukua), a Knife (kajiu) and the two sticks used to make fire (kirika and rurindi) into the bleeding hole. In turn, first the master, then the apprentice, and finally the two assistants swear on the goat, crouching down over the dead body of the animal, while holding the right leg of the goat (ithagiro) with the right hand and the instruments plunged in the slaughtered throat with the left hand. The wording used by each participant is as follows (I use my

kitharaka name M'Kamwara to indicate myself) .

M'Mburuki: 'I call you M'Kamwara and if I meet you on the way you should say ''That is my father''; and if I feel pain and I send for you, you should know that your father is sick, come and see me unconditionally. There is nothing harmful I can give you to eat or drink, or any knowledge to injure you. I have called you son. Since I have called you son, if you come at night, yes, you will sleep where I sleep'.

M'Kamwara: 'These agao today have initiated me: there is none of them whom I do not love. Agao, you are my friends, the Tharaka. Take me and consider as more than your best friend: whatever you want, ask me and I will give you. Today you have started to show me what is Ugao: now from today onwards you will show me everything. I will help you to the extent of improving your work of Ugao'.

Rukungi: 'M'Kamwara, today we are united with you to the extent that if I meet with you on the road, it is not proper you pass me without stopping. You are my child today. I was very pleased the day you came to visit me when I was sick. I see that we are becoming united with you; today I think that we are united. You look after what we are telling you and support us. Because you are my child, and today we are showing you Ugao and the next days we will show you again'.

Kinyua: 'This the oath that join all the people. Thus, M'Kamwara, on the time we met you first we had doubts in our hearts: today we have become blood-brothers, today you are my son and I am your father. If it happens that you come to know something that can destroy our group, if you hide it from us, this oath will affect you. Even if we know anything that could injure you and we do not tell you, we will be affected by this oath. And if M'Kamwara or one of us happens to be in trouble, even though it is at night we shall look after him until we see how well he sleeps or he improves. So today we have become blood-brothers, we have become children of the same mother. And we should not look after us on the path of evil'.

Once the oath is over, M'Mburuki removes the instruments from the throat of the goat and licks the blood on top of them; then he gives me and the other two people to do the same: by this, the gichiaro (brotherhood) has been established.

THE DIVISION OF THE GOAT AND THE COMMUNAL MEAL

The skin of the goat is completely removed and the different

parts of the body are cut by the three agao together: then a part is given to each participant to bring home whereas the remaining part is consumed together on the spot (the liver, the neck, some intestines, some ribs, the back legs and the stomach). The head and the skin are given to the eldest person (M'Mburuki); the lungs and some ribs are for the father of the initiate (my research assistant); the remaining ribs, some intestines and three legs are shared among the three agao; and the right front leg is given to the initiate. Finally, the breast meat is shared on the spot by the master alone with his initiate.

4.3 Day II. The Hand-over of the Horns

Friday, 23rd May, 1986

After the oath is taken, it is time to start to acquire the proper knowledge of the Ugao. The first stage consists of handing over what is considered to be both the symbol and the material instrument of the Ugao: the horns. Such a hand-over implies a particular ceremony which in some parts is really very moving: there is a strong awareness of the meaning of what is going on and the agao look very serious while fulfilling their roles with great concentration.

PRELIMINARY OPERATIONS

Before starting the real work, it is necessary to prepare the instruments and bless them. The horns of a cow and goat which I brought are warmed up on the fire to empty them of their

contents and to trim the upper edges with a knife: all these operations are done by Kinyua with skill. In the meanwhile, Rukungi prepares for me the kajiu (knife) and the mukua (needle) used to inject the mithega (magical medicines), putting a wooden handle and a guard on top of it. M'Mburuki stands quietly some way off, observing how things are progressing: his face is inscrutable as always. When everything is ready, he asks me to produce the eight gourds of beer I was supposed to bring as part of the payment: drinking a sip, he sprays a stream of drops towards his kiondo (a basket containing the mugao's instruments). The other two agao do the same action to their kiondo: it is 'guikia ita', a sort of blessing of the instruments 'to make them happy'.

INTRODUCTION TO THE HERBS

The three agao dig a small hole in the ground and leave on one side a bundle of herbs and roots they have collected in the bush. I am told to sit down in front of the hole, keeping the needle and knife planted in the ground near me. They tell me that they are used to dig and uproot the herbs in the bush and that we will now pretend to do the same.

The ritual starts with M'Mburuki marking my right eye and my two palms, which are joined to make a cup, with the white powder, iraa. Then, squatting down in front of me, he collects the herbs one by one together with each root and deposits them on my palms showing me what they are (so that I can recognize them in the bush). After that he marks each plant with iraa and puts them in the hole making them stand up. At the same time, the two

assistants repeat the operation of marking my right eye and open palms with iraa every time he collects a herb; then all together they close my palms around each plant and squeeze their hands while reciting a spell which includes the name of the plant. Finally, we put the plant aside on the ground. The wording used is as follows.

'Let us be friendly to the herbs (they spit); so that we can help each other (they spit). May they make you happy in the same way they make us happy; may you make them happy in the same way we make them happy.
The first herb is murindi (1), and this is its root;
the second herbs is called mwariki gwa nkoma and we are handing to you;
the third herb is called muti gwa kio: make love with it, love each other;
this one is mubiru and its roots (they spit): love one another;
this one is called muguna njau and this is called mutheki, with their roots;
this is mwerera and this one is mutubia njau (they spit);
this one is called muraqwa; this one is called mubuu and this is murua: may you love one another, may you love them;
this is called muchabi and this is kamama;
this herbs are used for making mithega and kioria:
there is no secret we are hiding from you; also, there is nothing you are hiding from us'.

At the end M'Mburuki takes a bundle of sticks with a small bell (mpingo) and put it around the herbs, to end symbolically their collection. Finally, we get up all together keeping the mpingo.

TREATING THE HORNS

Once the herbs are blessed and I have been introduced to them, Kinyua cuts them up into small pieces and puts them in a pot, adding also the skin of a snake. M'Mburuki observes while explaining to me:

'Now we want to prepare the horns with the protective

charms: this is called kuuma ngoci (treating the horns). The horns is strengthened with charms and herbs so that, in case it becomes harmful, you counteract it with this kioria (medicine). You will carry kioria separately from horns. Every horn has its own kioria. You may go with a horn and it becomes dangerous: therefore, use the kioria which I am using to counteract the horn. When preparing kioria, we use the skin of a snake called nguo ya njoka'.

After these explanations, Kinyua asks me for some coins with the number seven or a multiple of seven in the coin's date to be added in the pot; then he puts there the three horns they have prepared for me and he pours some mbiro (black powder) on the contents. After that he joins together the contents of the kiondo of all three agao and marks with iraa all their instruments as well as my horns while reciting this spell:

'It is a big tree where the birds rest. And you, today, there is none doing harm. I swear by all the oath, we desire peace, we desire goodness, we do not desire to go to bewitch (he spits). We need blessing, we need joy. If one is touched with this horn or drinks muthega with it (he spits), he wakes up, stands and he is contented (he spits). We are strengthening the mithega for you, to be powerful. What we are doing here is black muthega (muthega gwa mbiro). These are unbaked mithega from herbs'.

In the meanwhile, M'Mburuki is preparing himself by marking his right arm and leg with seven white marks spaced with seven red ones using iraa and red ochre. Then he drinks a sip of uki (honey) and sprays it on the content of the pot and on the kiondo of the agao after being seated with his legs around the pot. After that he takes rurigi (a strings with some marked sticks attacked) and makes a circle with it around the pot. Then he takes mpingo (a small bow with arrows attacked) and a horn and starts reciting a formula while pretending to shiver, kneeling down and waddling,making noises with his mouth similar to grunts.

'Njeru (Sun), you have already heard the news of today: please, hear, may I be blood-brother with him (he

spits). What we say, we shall be friends with him and him, for what we say, he will be friendly to us (he spits). Good bioria (medicines) which he takes with him, may he not panic (he spits). Thus I have said he is loved, may he be in love with them. Uprooting, yes, uprooting for Kirinyaga (Mt.Kenya), uprooting for Africa (he spits). You are kioria, I have not called you muthega, I have called you good kioria (he spits). Kiama, kiama, kiama, kiama (he spits).
A woman is bewitched on the left and it is the one I am blessing (he spits); even though a person is bewitched, once with these horns he will wake up and go. To do this, if it is mere water it is nothing, there is no kiama. Sun wakes us every morning: we wake up to go to start such work like what we have done today. We pray to help, we do not pray for a person to die (he spits).
This one who is with us today, we give him these herbs to go with them. There is no fear when he has them; even though he meets with someone with muthega, it will become mere water having this kioria (he spits).Kiama, kiama, kiama, kiama. As I have called you, thus he who does kno all the oaths. The sun has never failed to rise and you will also never fail to do your work. I have called you kioria, kioria; yes, I have called you kioria for healing harmful muthega in the body until he makes a person to recover. I have called you kioria to heal harmful muthega in the body. For healing all harmful mithega, even though it were that of vomiting, or that of Uthambara (Kamba), or that of Nyamwezi'.

It is now up to Rukungi to repeat the ritual after having marked his right arm and leg in the same way: he repeats the same actions with a simpler style, adding a circular movement by his right leg over the pot.

'I have called you kioria that heals harmful muthega in people's body; even though it is harmful muthega of any kind, even though it is of Nyamwezi or of Uthambara, or of vomiting, or of Giriama. All the biama are here (he spits). Catch up kioria, catch up; do not be left behind by muthega, catch up kioria. I have called you kioria for healing harmful muthega of any kind. For healing the harmful muthega of nyanjo, or that of Taita people. or that of Uthambara, or any other, even though it is from the Coast. They are all here, they are (he spits). I have called you kioria: you are bush herbs but now you are kioria. As I have called you kioria, you answer. I want you to please my heart and also our apprentice in the same manner I please him. Even though a person has gone over harmful muthega on the road, it will simply become dew (he spits). I want us to be united like a pumpkin and a cucumber (he spits). Kiama, kiama, kiama, kiama. Catch up kioria, catch up, do not be left behind by muthega. There is no kiama, it is like migration of ants, there is no kiama (he spits). This is the only kiama, there

is no other'.

Finally, it is Kinyua's turn: M'Mburuki marks him as usual, but also marks his tongue and the umbilicus; his style is more dramatic than that of his two colleagues.

> 'Even though a person has been bewitched with that, there is no kiama, even though it is a kind of mpingo, there is no kiama, even though he is sweating and urinating (he spits). I curse the kiama of bees, even though it is whatever kiama. Murungu (God), the work I am doing here it is not my work but your work. Say, whatever a person will ask for is what I will give. Four and again four (he spits). I call you kiama, he who does not know all the oaths. I have called you the most popular, he who does not know allthe oaths. I came to look for you as bush herbs, but now you are muthega. I have come to send you. I have called you muthega, I have called you kioria. Even though it is muthega of kiswahili, there is no reason to leave evil in a person's body. I curse the horns for bewitching people. I want peace, I want joy, I want blessing. Kiama, kiama, kiama, kiama. To combat is to combat: you combat all things that exist in this world - all, all, all existing in this world. Even though it is the kiama of a blind man. There is no kiama, kiama, kiama, kiama, kiama (he spits).

We have reached the final stage of the ritual, that of delivery of the horns to the initiate: they join all their horns in one kiondo and tell me to remove my shoes. Then I am made to sit down in front of M'Mburuki who marks my forehead, tongue and umbilicus with iraa and tell me to do the same with him. Finally, he marks my palms and guides my hands to pick up the horns; together with his two assistants, he squeezes them now in my hands, making me to draw some circles in the air while they recite this formula in unison:

> 'We, as agao, and this son whom we have initiated as agao, we want him to mature and to know all these herbs (they spit). We swear by all the oaths, stand on the earth with tip toes. May he help himself and may he help his relatives and his clan. Let us love one another, may he not refuse what we tell him and what he tells us may we not refuse (he spits). We shall treat you and treat you with the left hand, there is not even one side that I will leave aside. We swear by all the oaths, we have given

you. (they spit). This is not a joke: this is what is initiation. We have initiated him completely, go with them. When you go, it requires that you walk with them without fear to threaten all men until they start to shake because it is a good herb even though I am told. We have become blood-brothers, you have become our child. Do not injure us, we should not injure you. It is like oil, a good herb which loves you and your family (they spit). Let it love the work that you do (they spit). The good horn is that which does not hurt you. We have initiated you today, we have initiated you to become our good child who can ear things (they spit). We are giving you your things, take your things, carry then with you and may them help you'.

At the end we take the whole pot and we stand up all together : the pot with the horns is delivered to the initiate.

CONCLUSION

Before ending, my master and his two assistants properly conclude the preparation of my horns by 'closing' them: taking one each, they collect the pieces of herbs and roots from the pot and pack them in the horns together with the coins and some mbiro using the needle and the knife. On the top they put some wax to close it; on one, Rukungi adds three small red fruits of nchigo. They leave room on the top to contain the muthega to be given to the patient to drink. M'Mburuki ends even the preparation of the mukua (needle) by making a small hole on the top of the handle and inserting some oil, pieces ef herbs, and mbiro: the whole is sealed in as usual with the wax.

While they are completing these operations, I take the chance to question them about the meaning of 'kiama', a word they often used in the formulas. M'Mburuki answers me like this:

> 'You may go and find someone who has been bewitched and he is whispering 'Kiama, Kiama, kiama'. The meaning of 'kiama' is the manner of one who is bewitched: he was bewitched by kiama. They are called the biama of Urogi'.

The horns are now ready and they are delivered to me, ready to be used: the utilization, they say, will be explained me later on. Using some pieces of herbs which remain, M'Mburuki finally closes the ceremony by 'cleaning' the joints of everybody by touching them lightly.

4.4 Day III. In the Bush

Monday, 26th May, 1986

Since some herbs were not available in the area around Kibuka, the three agao had suggested we go together to collect them in the more arid areas near Kamarandi. Therefore, the third day takes place in the bush, on the steep hills around the Mutonga river some miles before it joins the Tana river.The three agao guide me along the track displaying a good knowledge of the place; sometimes they stop to show me a plant which is considered part of our craft and uproot it or cut off leaves using a panga (big knife). After gathering it, they go through each time a ritual of introducting the initiate to the herb: they tell me to squat and hold it in my hands and then to raise it up as though I had uprooted it, while they recite this formula:

> 'This is (herb name) for Ugao, even ourselves we were shown this one by a mugao. We have handed over to you in the same way it was also handed over to us. Now we introduce you to this herb in the way we told you we would do; then we will show you Ugao'.

At the end, we collected seven new herbs: mugokora, kaania kara gachege, gikuno, itumo ria tubu, kibiricha, muthunguucha, and muonkia. For each one they explain me which is the exact

part used (roots, leaves, bark,etc.) and the way of preparation (baking, grounding, soaking, etc.). Of some, they also add the kind of problem they are used to treat (mostly urogi). Kinyua also gives me some instructions about the right way of uprooting them:

> 'When you are digging herbs, you should go with a panga and make four straight parallel lines on the ground with it before uprooting them. If that herb is for treating a person to rise, you will find the roots like the lines you drew. So you remove two of them following each other, and then you you cover with the soil. The herb for treating urogi is not left uncovered; but that one used to bewitch is left uncovered'.

Since it is noon, they decide to halt the exercise temporarily and take a rest. They take me down near the Mutonga river, where it is less hot. We sit down in the shade of a tree called muthumuki and here I come to know the reason why they know the place so well: they were born here, and like many other Tharaka people they left here relatively recently (15-20 years ago) for upland areas such as Kibuka, since the land down here was no longer enough for everybody and too arid.

The afternoon session takes place below the same muthumuki tree where we have rested: it consists of a series of instructions concerning the horns and the medicines used with them. Firstly, they give me some explanations related to the horns I was given the previous time. They are called rugoci rwa mpingo, rugoci rwa kioria and rugoci rwa kurogora, according to their different purposes. For example, the first one is used for treating mpingo (a kind of bewitchment) together with kioria kia mpingo (medicine for mpingo). In each specific kioria like this there is a 'baseline' composed by the same herbs (the ones I

was introduced to the other day), plus some particular ones used for that problem: in the case of mpingo, they are mutambu, kania kara gachege and murira, plus the soil around the hole of a bird called mbutiti.

There are two fundamental types of medicines: kioria kia mbiro, in form of black powder obtained by baking the herbs; and kioria kia makie, in form of a thick paste obtained by grinding and soaking the herbs with water, and mashing them together with goat's rumen and blood. Since the other day it was not clear to me why they were using alternatively the word 'muthega' and 'kioria', I explicitely asked them about. M'Mburuki replies:

> 'When we say that we have given a person muthega, we imply that we have given him kioria. But muthega alone is that of urogi (sorcery). The one we are showing you is for treating the muthega of urogi. The muthega of ugao is to treat, therefore it is kioria to treat muthega of urogi. A murogi (sorcerer) is never a mugao'.

Kinyua also adds an important instruction on the way to use the horns:

> 'When we give you all the horns and you go to treat, you should not make a complete circle while blessing with them. When a mugao is treating he does not make a complete circle with the horns: he makes a semicircle. To make a complete circle is to bewitch'.

The last instruction is on when to use the horns: they should not be left out in the rain and the new moon should not appear when the mugao is still treating somebody in the bush. 'A mugao loves his horns in the same way he loves his children, whom he does not leave out in the bush at night', Kinyua states. Since the sun is already about to set, it is time to go back home.

4.5 Day IV. 'Miti Mikuru' and 'Ng'ondu'

Wednesday, 4th June, 1986

When I arrive at the usual tamarind tree, the three aqao are concluding the treatment of a boy: they are making some vertical cuts on the skin of the neck, on the stomach and on the back - where the boy is suffering pain, they explain to me - using a blade; and then they apply some kioria into the cuts. The cuts are three on neck, two on the stomach and two on the back: seven overall, a number closely connected with ugao, as I shall often find.

When they have completed the work and the boy has gone away, we start today's lesson. They inform me of their intention to complete my basic set of the mugao's instruments, giving me the mitimikuru and ng'ondu, which are not used for urogi but for another kind of problem called kibitana.

PREPARATION OF 'MITI MIKURU'

M'Mburuki takes three herbs, muti mukuru, mukenya and mukinduri. Their stem is cut to the same length - some ten centimetres. Then these sticks are wrapped in a small bundle about five centimetres in diameter using a string made up of goats skin. In the middle, he puts the front right limb of a goat (ithagiro), particularly the lower part with the hooves and the paw of a monkey (kayora ka nthang'a). My master explains the meaning of what he is doing:

> 'Miti mikuru was tied by the old mugao, it is put on the young mugao so as to treat children with it. According to our tradition, miti mikuru is for treating children of

kibitana, and there is nothing else it does. Miti mikuru contains muti mukuru, a twisting climber: therefore, it is to untwist kibitana and terminate it. A limb of monkey is used to add power to a person's ugao'.

PREPARATION OF NG'ONDU

Now it is up to Rukungi to prepare the ngondu, a special type of kioria used for Kibitana. He gets out from his kiondo four plants he has prepared: they are the roots of murindi, gakathi, kamama and the whole plant of ng'ondu. This is a ground tuber that stands for a sheep (they share the same name), being less expensive. Sometimes, mugumo can also be added. Seated, he pounds the plants all together using a stone. When the medicine is ready, he puts it in a small gourd (mpau ya ng'ondu) and gives it to M'Mburuki. M'Mburuki then puts it in a calabash together with miti mikuru, and adds the container with the black powder (mpau ya mbiro) and the two small goat horns he has prepared for kibitana. Then he marks with iraa all the instruments as well as himself on the umbilicus and on the tips of his toes. After spitting he starts reciting the following formula, while keeping his hands crossed over the instruments:

'Good horns of ng'ondu and miti mikuru, this you see here (he spits), in case a person was ailing he becomes as healthy as a lizard. I have called you 'horns of ng'ondu', I have joined you with miti mikuru and there is no disagreement with what you hear me saying now (he spits). Good ng'ondu (he spits repeatedly). May you be loved by ng'ondu of M'Kamwara; and if he goes to treat a person who is sick having entered the thighs of a woman during her menstruation (he spits), I swear by all the oaths, after taking these horns and miti mikuru and giving him water with these horns, there is nothing and he gets well (he spits). And if he gets up he walks like a calf of antelope, he walks without kibitana, there is nothing frightening in the body (he spits). Thus, I have called you, you were bush herbs but I have called you good ng'ondu. Those with ululations, those with a girl and a boy,those who

love M'Kamwara, he would go to satisfy a person with them (he spits). Those that bring children home so that they cannot be mentioned (he spits), thus I have called you good ng'ondu and miti mikuru to help a person even though it is kibitana, having entered between the thighs of a woman during her period, if he gives this muthega with these horns and touch him with miti mikuru, there is nothing, he would recover, thus I have called you good ng'ondu. If you go over someone with this mitimikuru, even though he has been bewitched there is no more sickness that would go back to him anymore (he spits). That is how I have called you: love one another like a cucumber and a pumpkin love each other (he spits). Good ng'ondu of nyambura (blessing)'.

At the end of his blessing, my master crosses his legs over the calabash containing the instruments while leaning on his palms and draws two clockwise semicircles . Then he steps over the calabash in the same position and stands up. Finally, he gives me the calabash with everything, after having marked my hands with iraa.

4.6 Day V. Illnesses Treated without Horns

Monday, 16th June, 1986

Today the spot of our usual meeting looks like a phyto-pharmacy: herbs, roots, calabash and bottles containing medicines of different colours (mainly reddish, brown and yellow) are scattered all over below the tamarind tree. The reason is soon given me: after completing the delivery of the instruments contained in the kiondo kia mugao, it is time to begin with the proper teaching of how to treat different problems. Later, I shall be shown even the way of practicing using rituals. First, we shall start - they say - with the kind of illnesses treated without horns. The teaching starts as a lesson, but later takes the form of a conversation because of my curiosity, which they

promptly satisfy, about some issues.

Rukungi: 'The first problem we want to talk about is called nyongo: it is something related to kanyongo (gall bladder), it is the one that grows very fat.It stays in the liver.That nyongo grows exceedingly inside and becomes too much. Then it flows through the veins and spreads until it fills the veins, the joints and the body: when it fills the veins, that is the time one starts to get sick.A person with nyongo shows it by vomiting, and vomits nyongo. He vomits a very yellow nyongo and urinates yellowish and greenish urine.
A person is affected by nyongo because of eating those things which are sour, such as uchuru (porridge). Nyongo is caused by the food you eat: the sour food that is taken goes straight to the gall bladder, which acts upon the food you eat. A persons vomits a yellow substance: the gall bladder is the one that releases a drop into the food and it starts rotting in the stomach. There are other things which can cause nyongo, because even cold food happens to be sour, though not so very sour as the food that has salt.
If you take the herbs, nyongo will pass through urine making it yellow; also in the stools, and with a lot of sweating. Nyongo is treated using sixteen herbs: by the roots of mukagwa, mwogore, mukururu, mugenda na akuru, muthugathugi, mutongu, mukaranyakini and miirendatha; and the bark of muguchwa, muthuci, muura, mutuuma and muthumuki; the roots and bark of mukuria mpungu and the branches of muthunka. I take all these plants and crush them, wash and put into a pot with water, cover with a lid and boil.
After boiling for an hour , I take the liquid, filter it and and put it in this bottle (he shows a bottle containing a brown liquid). When a person gets sick, I give him a dose of two spoons for the first day and two spoons for the second day and nyongo is finished.

M'Kamwara: Is what you call 'nyongo' the same of what is called 'malaria' today?

Rukungi: It is the same as malaria.

Kinyua: 'Now we talk of rwaro (diarrhoea): it is a very bad illness. When someone has rwaro, the intestines are bad: the food one eats does not get thick and the stools too.
There is rwaro with blood and there is another rwaro which has no blood; and there is rwaro with maira (pus).
When we are treating rwaro, we do it differently. The rwaro with blood and pus are treated the same way, because the pus becomes blood. They are treated with munagwi (he points the herb) alone. Munagwi is also used for kirumati (stomach ache); even when someone passing diarrhoea is suffering from kirumati. The rwaro with no blood is treated with the roots of mutagata, mutithi, mukuria mpungu, mwira ndathe, mugugwa and mukururu, and the bark of muthithti. They are washed and boiled into a pot in small pieces: then

the juice is given to a patient with a dosage of two spoons if he is adult, or one spoon if he is a child (he shows a bottle containing a yellowish liquid).
The rwaro with blood and pus is caused by kibitana: in case a person is suffering from rwaro and after treatment he does not recover, one goes to the muringia (diviner) to detect the real cause. Then, once he is told it is kibitana, he is treated for that.
When a person has rwaro, he may even have njoka chia nda (intestinal worms):they can cause a person to have diarrhoea because they pierce the intestines and a person starts to pass bloody diarrhoea. Njoka cia nda are of two types. There are white worms and red ones, and there are those called ndanguru or irimo. The red ones stay in the veins and they also pierce the stomach. Those white ones, which are very thin, stay in the intestines, in the stomach and also in the veins and in the eyes. Irimo look very white as paper. They are as big as the size of the smallest finger of a child. Yet, they are flat and they divide themselves. A person with irimo has sores on the body when he eats meat.
Those thin and white worms are treated by chewing the roots of kariqi munana;the other types are treated by boiling the roots of muguruka and the bark of mwarwa and drinking the concoction with soup or porridge. Also marenge (pumpkin) are eaten in great quantity.
There are worms which are inherited and there are others which are caused by water or by eating uncooked meat. A person is born with some vein worms'.

Mburuki: 'There is also a new illness called gichonono (gonorrhoea). When passing urine, one feels a lot of irritation and has a stiff erection and sometimes one is unable to pass urine. The pus also comes out, and after that one sees blood coming out together with the pus.
Gichonono is caused by a woman's blood: it happens when it does not match the other person's blood. Then the latter become more powerful because it is stronger than the former. It is unable to flow, then it starts to clot and become pus. This makes the person sick.
There is also gatego (syphilis ?): one gets sick when one is attacked by some things which eat up the penis. They also eat the genital part of a woman. They enter through the penis: after entering, it begins to grow as a wound. It comes from a woman who does not shave her pubic area: she knows how to hide the dirt that produces worms. After producing worms, those worms stay on the side of the vagina and they multiply inside it. When a man goes to sleep with this woman, the worms will enter through his penis. After some time, the penis starts to swell as a result of those worms. It continues to grow as a wound: when it reaches the base of the penis, it grows bigger until it cuts the penis. It also hurts quite a lot.
Another murimo qwa nyamba (illness of the genitals) is when one's testicles get swollen. It is called ikubu or musiba (orchitis ?).

Gatego and gichonono are treated in the same way. You use the roots of three plants: mukururu, mukumukumu and mubabai. They are boiled with water for about twenty minutes after cutting them upin small pieces; then this juice (he points to a bottle containing a reddish liquid) is filtered and drunk for two or three days, morning and evening. The illness of ikubu is treated differently: it is divined for, because one may have mpingo (kind of sorcery), or in case of somebody's wife it is necessary to divine to see if she has misbehaved or the dirt has entered into the penis of the husband, so that it is known what it is exactly. Ikubu is treated with horns because a person does not know the cause: we treat it with the horns of mpingo and kibitana.
These illnesses of the genitals came from across the Ocean. They were not here in the old days. There was only mpingo here. When I was in Mombasa, I was employed by a British called Frinda: he is the one who told me that the illness that spread in Kikuyuland came from the white people, from across the Ocean and it originated from dogs. The old Ugao did not know about gichonono and gatego. Even today, those old people still alive of the nthuke (age-set) of Nkonge, if you go and ask them about these ones, they would not tell you. Some Tharaka agao came to know because they were directed when they were sick and told to uproot such and such herb, drink it and recover. This is how they have come to know about the treatment from those who had been in Mombasa. I was told by the father of Gatana from Mombasa, my father-in-law of Nduruma clan of the Giriama people'.

M'Kamwara: 'Why do you not use horns to treat all these illnesses?'

M'Mburuki: 'Because these illnesses are not caused by urogi (sorcery). They are brought about by such things as water or eating uncooked food, or sharing food together with sick people. We just give a person ndagwa (medicine) the way the doctor gives a person tablets in the hospital. A person is given medicine according to the way he feels in the body. The mugao knows it is not urogi but a certain illness which has attacked him with no particular reason. So he would prepare the right herbs for him. These herbs you are shown today, that is what we met our forefathers doing'.

M'Kamwara: 'Do you divine in order to detect the causes of these illnesses?'

Kinyua: 'You divine to see whether the person has other reasons for falling sick, such as urogi or something else. If there are only those simple reasons, the patient is just given herbs to drink.'

M'Kamwara: 'Are these herbal treatments known only by agao or by common people too?

M'Mburuki: 'These treatments are known only by agao. If you give a person a bad herb and he dies, what do you say? You must

be shown herbs by the mugao, like that mugoti you see (he points to it) is good for the treatment of nyongo. But some of these herbs are known by common people, only they do not know them properly. Those who drink these herbs have grown up together with a mugao. However, when they see a mugao drinking these herbs, they are the herbs they use, and cannot add more. For example, a wife of a mugao like Kinyua knows these herbs'.

4.7 Day VI. 'Mugiro' and 'Kibitana'

Monday, 21st July, 1986

When I arrive together with my assistant, I find the three agao waiting for me, quietly sitting in the big shade of the tamarind tree. After having completed the first part of my training - they tell me - it is time for the novice to be introduced to what is considered the central part of the Ugao. My master and his two assistants will start today and the next days by drawing a picture of what are considered the main reasons for illness that is unrelated to any kind of urogi (sorcery): each day they will deal with one or two of them and the following day they will show me the proper ritual for treating them. Today we shall start with mugiro and kibitana.

M'Mburuki: 'Mugiro is caused by the death of a person. A girl contracts mugiro from her father who is dead, or her mother or a child of the home.If a girl is married when a person is dead in her home and the rukuu (impurity) is not cleansed, if she goes to the husband he contract mugiro'.

Rukungi: 'If it happens that the husband is dead, the wife will meet with another man from the bush to cleanse rukuu with him, because that is his thing (she belongs to her husband). She looks for a man from the bush whoever he is and cleanses herself with him but this man from the bush cannot be affected by rukuu because he is a thief, he is stealing. It is only once, once he ejaculates the woman does not want it again. If the woman repeats the act with a man again, the rukuu is not cleansed, she is defiled. It returns to the person if one repeats the action twice because they behave

like husband and wife. Once he returns to her again, he returns the rukuu to her because he has repeated the action twice. Even that woman does not happen to be lying down, she happens to be sitting down and they do not embrace each other. A woman will not like to be embraced because they are well instructed. If it is the wife who is dead, the husband looks for another woman in the bush and he cleanses with her. If it happens that it is a child who is dead, the wife and the husband cleanse themselves provided the child is not married. They do not cleanse themselves in the bush, they do it in the home'.

M'Kamwara: 'What would it happen if they do not do anything?'

Rukungi: 'Their children are defiled, they become disabled, they get sores and even the goats die. This is the way mugiro is contracted, becoming thin, with joint pains, backache and soles on the whole body. It could even kill a person because of these problems: a person could have the blood finished and then dying.'

Kinyua: 'During the first period, a person with rukuu cannot fetch water in the same ford with other people, he fetches water in his own place alone. He cannot be assisted to carry water or loads by any person. He cannot be washed on the back by any person. If she is a woman, she fetches water all alone until she see the monthly period again.It is cleansed with blood: the day she experiences her monthly period, is when she goes to look for a man with whom to cleanse rukuu. Her hair is also not shaved. After doing that, she looks for an old woman who is has ceased menstruation and it is she who shaves her. After the shaving, she sleeps and then is taken to the road. Then she passes through a flow of goats and she goes to sleep at the ford (as a sign that she was cleansed), and starts fetching water along with others. She should also not eat honey.
If the person with rukuu is a man, he waits until the moon disappears in the sky (the month ends). The month is counted with the coming of the new moon: the rukuu is cleansed and the children have to be at home. The day the rukuu is being cleansed nobody should be outside the home. It is cleansed at night, when all the children are in bed'.

M'Mburuki: 'If there is a son of the family who is outside the house such as in Mombasa, the day he comes back he will be received with a goat and have nkooro (charms) put on him and 'washed' with the leaves of mukenya, mwagere and mukindu'.

M'Kamwara: 'Are they prohibited from eating any type of food during the time of rukuu?'

Kinyua: 'The children can eat everything but the parents cannot eat meat of goat, honey and milk. So that the goats and bees do not get killed by being affected by rukuu. During this period of rukuu, even the friends of the family are not

allowed to enter the home or to mention them, except to greet them. The day they cleanse rukuu, the children are not shaved, only parents are shaved. If the husband was dead, the wife is shaved; if she is a woman who is dead the man is shaved. The woman is shaved by the person she cleansed herself with'.

M'Kamwara: 'Is there anything else that can cause mugiro apart from rukuu?

Rukungi: 'Mugiro is caused only by rukuu. There is nothing else that can cause a person to have mugiro'.

Kinyua: 'The girls who take medicines to abort and sleep with a man then they transmit mugiro of the back. These days most men are defiled this way'.

M'Kamwara: 'If a woman sleeps with a man during her monthly period, can that person get mugiro?'

Kinyua: 'That is called kibitana, not mugiro.Even to take a woman from behind like a goat is a very bad kibitana. You start feeling pain at the back, stomach ache and even get bloody diarrhoea and loss of strength to walk and pain in the pubic area, or it swells. A woman sexed by her husband during her monthly period, takes him and treats giving him muthega of kibitana by putting it into the body through an incision in the pubic area and on the back'.

M'Mburuki: 'Kibitana is caused as follows. A person may come and borrow your garment such as the one you are wearing. He goes with the garment and if he is a man when he goes with a woman by bad luck he does not remove it. That is one type of kibitana. You may go to town and you buy all kinds of food. You take a woman while you are carrying them.That is another type of kibitana. It is the home that is defiled. You do these things outside the home before you come back. Once a person has done that, he goes and cut the ears of a kid. If you take your garment and lay it down for your wife to lie down, that is very bad kibitana. Or when the food is on the fire and they have sexual intercourse, it is kibitana that defiles you while food is on the fire. It is caused by bad behaviour from women; it can affect a man or a woman. If you have well behaved, it will not affect you.
You have heard that long ago there was gaaru and people were forbidden these things, so that these ibitana do not multiply in the country to prevent people from dying bad deaths. And it is the one that prevented a woman from speaking with another person from outside. For example, a person may go to sleep and dream with a woman being in the bush with no home. If you dream with a woman at any place she may be, when you go and find that your people are not in the home, you should not go and enter into the house: you should stay outside and you are offered food , then you eat it and you go. When your people come, they all enter into

the house: then you also come and enter your house, because if you enter when they are not inside, you defile the children and the woman.
There are also children who remove clothes sometimes, and you see them outside when you know you are going to meet with your wife. You should collect the clothes and put them in the house. Because these clothes come to be 'closed outside' it is kibitana. You go and look for a mugao: he takes these clothes and returns them to the child with the ritual of kibitana.
A man going to sleep with his wife who passes over the children on the bed, that is kibitana. Another type of kibitana is when the children go to bed: the mother should check the mouth to see whether there was any child who went to sleep with food in the mouth, because if she has sex with the husband while the child has food in the mouth, when he (the child) wakes up he swallows.That is a very bad kibitana. If it happens that the child is not asleep when you are performing sex with your wife, that is a big kibitana. If the child is sucking and you are performing sex, that is another big kibitana, and the child is likely to die'.

M'Kamwara: 'Do people go for divination to disclose mugiro and kibitana?'

M'Mburuki: 'Yes, people go for divination. The mbugu (divining instrument) discloses very easily: it is the one that tells. All these things are known through the mbugu'.

M'Kamwara: 'Do common people know about mugiro and kibitana?

M'Mburuki: 'It is the agao who know the causes when they divine. But even the older people and some people know a little. These people know what to do to prevent trouble because long ago, when they went to the gaaru, they were told these things so that they knew how to prevent it. If your father was a mugao, you were taught ugao when you became adult.But if you are not a mugao, you went and looked for a mugao to teach you'.

M'Kamwara: 'Do the mugao use horns to treat kibitana and mugiro?'

M'Mburuki: 'There are no horns we use to treat them: but if you come on the next few days, we can wait for a patient who is supposed to be treated for kibitana and we can show you what we do to treat kibitana'.

4.8 Day VII. Ritual of 'Kibitana'

Monday, 28th July, 1986

The following week, since no patient had come with a problem of kibitana, my master and his assistants suggested me to go and attend the ritual at mugao Kigwato's home, a friend of theirs who was treating a young woman with that problem. When we reached the place, I find that the patient is a 24 year-old woman who has stopped having children after her first born: she will be treated together with the husband. Kigwato will perform the ritual, while the other three agao are sitting along side.Kigwato is an old experienced mugao, a small person with a big nose and a funny hat always on his head. I already knew him, and I particularly appreciated his friendly way of joking about everything. He takes the little gourd with iraa out of his kiondo and makes a white mark by the side of his right eye. Then he asks the woman for the 20 Shillings payment for opening his kiondo and beginning the ritual.

PREPARATION AND BLESSING OF 'NG'ONDU'

Kigwato sits down in the shade of a fig tree a few metres from the home compound and begins the preparation of ng'ondu, the medicine used to treat kibitana. He takes the roots of murindi, gakathi kamama and the small plant of ng'ondu, puts them on a flat stone and starts crushing them in the way I had already been shown. When the stuff has become a paste, he puts it in a calabash.

After that, he cuts out some thin strips, about 15 cm. long,

obtained from the bark of the ng'ondu, and ties them two by two until he has obtained four rings (the bark of the plant replaces the skin of the sheep when a patient cannot afford it). Then M'Mburuki takes the pasty ointment and divides it into three parts which he places into three small calabashes, covering them with the strips of ciang'ondu he had previously made; using some iraa, he finally draws short white lines on everything. After having marked the tips of his ten fingers with iraa, he takes out of his kiondo the miti mikuru and the mpau ya kindaji (a small gourd specifically used to treat kibitana). Sitting in front of the three calabashes and holding these instruments, he starts reciting the following spell to bless the ng'ondu:

> 'The ng'ondu that touches a woman and though she stopped bearing she feels well. She gives birth to fathers, she gives birth to mothers, boys and girls, they fill Kenya. In case she was defiled by a woman or a man (he spits), even women today are here and they will defile (he spits), if she ate kamuti (misfortune) of an evil person, a person with two umbilical cords (he spits): I have called you the good ng'ondu which treats a woman who would continue bearing children while she had stopped. She gives birth to fathers, she gives birth to mothers (he spits).
> I have called you beautiful ng'ondu, those good things and those with goodness. Even if you are bewitched by a woman or a man, or defiled by your father and mother, then you lack a child (he spits), you stretch the hands to the baby and is is born. She gives birth to fathers, she gives birth to mothers, boys and girls. That is what I want (he spits) (pause). To be touched with this ng'ondu (he spits), to be put nkooro (he spits), to be removed nkooro, I swear by the truth to remove all the evil things (he spits). She will be left on her own such that she is as smooth as the skin of a lizard or a river beetle (he spits).
> Beautiful miti mikuru, those miti mikuru which are good (he spits); mpau ya kindaji, which will help in the growth of an healthy body (he spits), I have called you good ng'ondu (he spits), it is not poison but a good helper (he spits) to help Kenya. Those good horns which struck a lady and she wakes up, she gets her children even though she has been defiled by her parents (he spits). I want good ng'ondu, but those ng'ondu that are helpful, those which help a whole nation (he spits). It is for a person to be touched with

ng'ondu after defilement because of either the father or the mother, he may err and goes to touch what has never been realized. To be touched with this ng'ondu is to grow as healthy as a lizard. She would have good blood, the bad blood spreads out (he spits), it comes out and goes (he spits).'

At this point, the mugao pours some water inside the small calabashes in order to make the ointment more fluid for the treatment - 'As smooth as the patient after the treatment', he says jokingly - and then he takes a bundle of herbs called gakuri and makes two bunches.

RITUAL OF THE GATE

Now everything is ready for the ritual. The first part of it takes place at the gate of the household. The mugao calls the wife, who is standing aside,to assist him. The patient is made to sit down upon a mat which is put in front of the entrance, consisting of a thorny hedge with a hole about 1 metre large. Kigwato puts the strips of ng'ondu bark (nkooro) around the patient's forefinger and the middle finger of both hands and the second toe of each foot,in the form of rings.Afterwards the mugao takes one of the three small calabashes containing the ng'ondu and pours some of the contents on the patient's feet, and the remaining part all around the mat (clockwise), upon the patient's head and all around the mat again (anti-clockwise). In the meantime he chants the following spell:

'Let me pour ng'ondu on you, let me pour ng'ondu on you (many times). Be healthy grandchild and stand strong like the sticks that hold firmly the hide of a shield, be healthy our child, be as smooth as a lizard (he spits).
Generate girls and boys, you stop going out without. See always good blood (menstruation), even though someone bewitched you or defiled you (kibitana).
Be healthy and as smooth as a lizard, child.

Today is when you have come to see the good person (the mugao himself)'.

With the assistance of the wife who holds his wrists, Kigwato touches all the patient's joints, from head to feet while holding the miti mikuru and a bunch of gakuri in his right hand and the mpau ya kindaji together with another bunch of gakuri in the left hand. He touches all the patient's joints drawing circles in the air with these objects; in the meanwhile he repeats many times 'Ng'ondu, ng'ondu, ng'ondu'.

Afterwards, he goes behind the patient's back and slips his arms under the patient's armpits and makes her lick the two bunches alternatively, always with the assistance of the wife holding his wrists. After licking,she spits each time. He repeats the same operation slipping his right arm under the patient's left knee and vice versa. Finally, he puts the instruments onto the ground and starts removing the nkooro (rings)from the patient's fingers and toes while he recites the following spell:

'Be unloaded (cleansed) those things of kibitana and those of rukuu (death impurity), those which were of evil things. Those which were brought to you by a person with a paw, you will be smooth and smoothed as the lizard.
Your sleeping mat is your nyambura, which was taken and entered into another woman's house because she hated you.
Snatching the blessing, even before they reached you saying she is bewitching you; saying, damn, never be well. That woman who was in a place - be smooth and smoothed as a lizard.Be well in all things (he spits).
Something that came from behind, that you never knew what it was, or what origin, that came tiptoeing to you at night or during the day. Leave the child that made you eat gendaga, that came towards you running fast with fury.
Generate girls and boys, give birth to good ones, generate fathers and mothers; generate all sexes, give birth to your relatives and also me. Be well and smooth like the lizard.
This thing came from behind, you never saw it, you never knew how it was. Be well as castor oil or as sheep fat.
This kibitana has to leave you, being of a woman or a man.
Even though it was your husband who brought it to you: there is nothing, all those things should leave you.

Vomit that thing which brought problem, which came clinging on you, which came from behind, which came from under the legs. Vomit what you ate without knowing. Be well and smooth as the lizard; give birth to children repeatedly. Vomit that thing that came from under the legs. Give birth to boys and girls, I want them.
Kibitana came, you were offered meat through an opening; it came through bad herbs. It was bound. Ng'ondu is to remove this, to remove those things which are evil'.

RITUAL OF THE HUT

Once the ritual of the entrance is over, the patient is made to stand up and is led - with the mat rolled up - by the mugao and his wife holding her arms towards the hut. They get her to step over the calabash on the ground containing the ng'ondu. When they reach the threshold, the patient is made to stop there whilst the other two persons enter inside. Here the mugao takes the second calabash containing the medicine and pour some of the contents on the line of the threshold. Then he makes the patient step over it, while holding her hands as well as his wife's. In the meantime, they repeat together the following spell from inside the hut:

'Let us receive you with ng'ondu, we receive you, child, with ng'ondu, we receive you with ng'ondu (many times). Trample on ng'ondu, trample on ng'ondu (many times)'.

Then the patient is made to sit in the middle of the hut upon the mat facing the entrance. Kigwato pours the remaining contents of the calabash all around the mat, repeating the same spell said at the threshold, but with one variation: the mugao slips his right arm under the patient's right leg and then under her left leg. The words of the spell chanted during this action are also different:

'What belonged to the kamuti (plant) which was

eaten by a woman, what belonged to that only child (a single child born in the family): I make you vomit the thing of kibitana which you were defiled by a woman, or your father, or your mother. Be cleansed today, this is the time you are cleansed, so that you are as smooth as a lizard.
Let us hold the child to come and trample on the ng'ondu, to trample on the ng'ondu, to trample on the ng'ondu.
Let us pour ng'ondu on you, let us pour ng'ondu on you, let us pour ng'ondu on you (many times).
May the ng'ondu love you, may the ng'ondu love you, be blessed with the ng'ondu.
Let me sprinkle you with ng'ondu, let me sprinkle you with ng'ondu, may the ng'ondu love you to be as smooth as the lizard.
If it is mugiro of the person who belonged to Gatue (village), vomit the thing that came at night, the thing of the only child, the thing of kindaji, those things of the night, the things of rukuu. In case the body had a problem, vomit those things. Vomit the thing that came from under the legs. Vomit the thing of gendaga you were made to eat by someone bound who hated you. Be smooth, smoothed as the lizard. Vomit the thing that came through the evil opening. Vomit the thing that belonged to the only child. Vomit that thing of rukuu. Vomit that thing of the night or of darkness. Vomit all things. Be well, be well as the lizard'.

The final part of the ritual is carried out upon the bed, where the patient is made to sit with her legs hanging down: the mugao removes the rings of ciang'ondu (nkooro) from the patient's fingers with the assistance of his wife, and moves them round the patient's wrists, ankles, head, and waist, repeating continously:

'Let us remove the ng'ondu, let us remove the ng'ondu, let us remove the ng'ondu (many times)'.

Finally, Kigwato takes the miti mikuru, the mpau ya kindaji and the two bunches of gakuri, and dips them into the third calabash with ng'ondu. Then he touches the patient's head, breast, and all her joints many times with them, assisted by his wife who is holding the woman's wrists. During this action, he repeats many times:

'May I be blessed with ng'ondu, may I be blessed with ng'ondu, may I be blessed with ng'ondu (many times). Wait to be blessed with ng'ondu.
Let us cleanse the child with ng'ondu, let us cleanse the

child with ng'ondu (many times); give birth well, so that when I come (to your home) I will be stoned (by your children)'.

4.9 Day VIII. 'Kirumi'

Wednesday, 5th November, 1986

After a pause due to a long absence (I have been in Italy and in Tanzania), I start again my apprenticeship as a mugao. When I reach the usual place under the tamarind tree, I find that the three agao are quite gloomy:the failure of the recent crop is threatening most families with hunger once again. Kinyua had also the misfortune of his house catching fire because of the wind and, probably,of the carelessness of his neighbour who set fire to his shamba before the sowing-season. After having reported the issue to the Chief, he had decided to give up and forgive the neighbour who is quite poor (a civil case is long and expensive, and a source of hatred).

They also tell me the story about the 'battle' of Thorema between the naked Tharaka warriors with bows and arrows and the police along with the D.C. of Meru, who had come to change the boundary between North Tharaka and Imenti, to the benefit of Imenti (some miles). M'Mburuki states firmly:'When a Tharaka says no!, it is no!' and the other two nod in assent. They openly consider the battle a tribal victory to be proud of.

After this preliminary conversation, we move on to the topic of the day: kirumi. M'Mburuki and his two assistants start teaching me as usual, explaining the meaning and the implications of this Tharaka concept.

M'Mburuki: 'Kirumi follows by saying, 'You have eaten something belonging to me by force because I have no strength to prevent you from eating; but since you have eaten, when I die, you will never eat something belonging to me or to my relatives'. Kirumi follows mistreatment, because if I curse a person who have not mistreated me,kirumi is not effective. I curse him and say, 'That thing you have taken from me, never eat that thing; if you eat, may kirumi affect you: you die, or you become mad, or you become insane, screaming or if you go and find somebody's property you destroy it''.

M'Kamwara: 'Is kirumi effective even though one does not pronounce the curse explicitly in front of the cursed person?

Rukungi: 'If I remain quiet and I do not tell him, 'You will become mad', he will not. Kirumi follows what the enunciator says, what he say a person to be. If he does not say what should affect you, you will not be affected'.

M'Kamwara: 'Can kirumi become effective when the cursing person is still alive?'

M'Mburuki: 'If you curse a person, he will not be affected before you are dead. The one who has cursed has to die first: then it is when the cursed person is affected by kirumi'.

Kinyua: 'Secondly, kirumi is as follows: I come to your home and marry, I take a girl from your home. But then it happens that I do not take care of you in a good way as father-in-law. When you request me to help you on work, I do not come. Or sometimes it happens that I drink beer and after drinking I come and abuse you. You may even curse my children by telling me, 'Never eat anything on their behalf! Because even me, I am not eating on behalf of my child whom you have married. And the manner you are abusing me even your father-in-law will abuse you in the same way. And do not feel ill in your heart because I do not hate you, therefore, accordingly, do not be annoyed to beat (my daughter)'. Such is what you hear to be the most effective kirumi, what takes a person suddenly. Such as if we were eating something together and you see someone cursed like this getting choked up and he dies'.

Rukungi: 'Another case is when your father-in-law is asking you for a goat to eat or it happens that you have something remaining unpaid (in form of dowry) and he asks for it and you refuse, saying to him, 'I will not give you: I paid the dowry and it is finished'. Then the father-in-law tells you, 'Because you have refused, never eat anything on behalf of your daughter', or 'Never be helped by your son-in-law, and never tell him to give you something to help yourself'. It is inevitable that kirumi will affect you'.

M'Kamwara: 'What other types of kirumi are there?'

M'Mburuki: 'Kirumi depends on the reason for being cursed.A woman curses her husband or the husband curses the wife. Even somebody's child can curse a person, or a married daughter can curse her mother'.

Kinyua: 'For example, a child curses his father if he assisted him get a wife and then he looks, and when he buys something he comes and eats because that is his child, without asking him. But his children will be dying of hunger as a result because things are not enough while his father is eating. By bad luck, an illness comes and it happens the son dies, before he can curse his father by saying, 'Father, up till now,for these children of mine, I had things to feed them with food and you are the one who is preventing them from being sufficiently fed. From now on, and after I die, never eat again anything that is left'.
Other types of kirumi depend on the situation: there is no kind of situation which cannot produce a curse. Kirumi implies mistreatment. I may bewitch you and you are unaware and when you are overcome with illness say, 'If it is a person who has killed me, before I die, as my neck separates, may he follow me''.

M'Kamwara: 'What are the symptoms of kirumi?'

Rukungi: 'Kirumi makes a person become mad, or just insane and he wakes up at night and walks into the bush. Or, if he finds somebody's property he starts damaging it. He can walk on roads one is not supposed to go through and there are times he can become unconscious. Or he eats something and he dies suddenly. Many people are affected by kirumi, such as when, for example, we are eating something and a child comes along and if he has strength he could snatch it from you and beat you. He takes that thing and eats it by force. You tell him, 'You will never step where I am stepping'. Such a kirumi is likely to make you mad until you become a complete weakling'.

M'Mburuki: 'If it is food that was cursed, once he is offered food, you will see him drinking only water or eating soil. And he has a lot of asthma.
There is another type of kirumi when you force a woman to lie down. Once you have done that, she holds your penis and you die. Before you can curse the girl by telling her, 'As you have held my penis you will never see such a penis'. She is married in a home of somebody: she gives birth to a boy, she does not suckle, she eats the penis with the teeth or she holds it and pulls it off and he dies.'

Rukungi: 'Many people you see in town, especially women, are those cursed, mostly over food. Sometimes because of mistreating the father or the father-in-law. Or sometimes they give medicines to the children of others and they die, or they beat children when they hide the blood of the

menstruation and the child dies.'

M'Mburuki: 'If a daughter was beating her mother, those hands may shorten and reach the neck or she walks with them raised this way (demonstrates); if she used to walk beating people with them and abusing them, she starts walking like that and moving the lips as if she was talking alone'.

Kinyua: 'It happens that young people force girls of other families to lie down at home, removing their clothes and beating them: those girls tell their mothers and they curse them saying, 'Be damned, son of so and so, it is not good for you who have done this to my child, may you be eaten by this standing murura (plants)'.

M'Kamwara: 'Do common people know about kirumi?'

M'Mburuki: 'There are even common people who are taught by elders the things concerning kirumi, wisdom comes from elders. Your father tells you and you tell your children. But if you want the muthega for kirumi, you go to the mugao, he knows the muthega for kirumi. Kirumi is ancient and it has been there for ages'.

Rukungi: 'A boy was told in the gaaru during circumcision not to curse his father or father-in-law; and also the women of your mother's age-group, you should not pass close to them because they will start saying that you have no respect for them, that this is a child of the age-group of my son, may he who lacks respect be damned . Young people are the one who are mostly cursed because they have strength and they are defiant.'

M'Kamwara: 'Even those who believe in Christian God believe in kirumi. This person called Ikunguru, brother to Rugera, was cursed by his father and told that if he collected honey from hives not to try to hide the honey. But he went, collected the honey and hid it in his house. He never followed what the father had told him. When he cooked the raw honey, he tasted it to test if it was ready: he drank the honey with a calabash and he swallowed and choked. It never passed the throat and he died.'

M'Mburuki: 'Another man from here called M'Naari of Ruguru was killed by hunger while his wife cooked food and refused him. He told her, 'I have died, I was not satisfied, you refused me food and I slept hungry while you slept satisfied: as I die also you, you will never eat anymore and be satisfied'. As soon as she was left, when she ate and was satisfied, she died. She died with the stomach being very big.'

M'Kamwara: 'If someone is not a Tharaka person, can he suffer from kirumi?'

All agao: 'He can be affected by kirumi, even a white man can be

affected by kirumi : kirumi is like an oath.'

M'kamwara: 'Can he be treated by a Tharaka mugao?'

All agao: 'Yes, he can be treated and recover, provided that the mugao knows how to treat this problem. There is no mugao who cannot treat kirumi, wherever the patient comes from. And all are treated in the same way, even if one is a Kamba or an Indian'.

M'Kamwara: 'How can common people know that they have been cursed?

Kinyua: 'Many people, mostly those who die because they do not go for divination but go to the hospital and kirumi cannot be treated with ndagwa (medicine) there, therefore the person dies. Those people who go for divination are the ones who are treated and recover. A common person does not know he has kirumi: he goes to the muringia (diviner) and tells him he is coming for kuringia (divination): he takes his things, acts with them, observes them and if there is a kirumi he will look and tell you you have kirumi'.

4.10 Day IX. Ritual of 'Kirumi'

Wednesday, 3rd December, 1986

I waited for quite a long time, but finally patience was rewarded. As we had arranged, when one of my three masters would going to have a patient suffering from kirumi, he informed me so that I could observe the ritual. It was M'Mburuki who called me; and it is to his home that I am going with my assistant. Better still, he has two homes (and wives) in two different places of Tharaka, and it is at the one near Chiakariga that we have to meet.

When we reach the spot, we find that everything is ready, M'Mburuki is busy preparing some herbs, assisted by the other two agao. The patient, a young lady who was cursed by her father, is quietly sitting on one side.

When the herbs are ready, M'Mburuki gives them to Rukungi who crushes them with a stone and puts on the fire in a half-broken pot marked with iraa, after blessing them by sprinkling them with water. In the meanwhile M'Mburuki starts preparing a little doll made from muthigu (a fruit) with the knife. At my request, he explains its meaning saying that it stands for the person who had made the curse. Then he takes out of a small bag a goat's head he had prepared and puts it on the ground. It will be used - he explains me - later on, during the ritual: it represents the accurser, too.

When the muthega (medicine) for kirumi is ready, Rukungi removes the pot from the fireplace and puts it on the ground to be blessed by M'Mburuki. The latter starts the blessing ritual by making semicircles on the ground all around the half-broken pot containing the medicine, first clockwise and then anti-clockwise, while spitting and reciting this spell many times:

> 'I have called you muthega of kirumi, thus have I called you. And if it happens you hear that a person has been cursed by a woman, by a girl or by in-law (he spits), a good horn to give to a person muthega and he recovers and stops feeling bad (he spits). There is no more of your being told kirumi,to be given these herbs means you recover, you walk, you give birth to relatives and clan. I swear by all the oaths. The good herbs that are in love with the one uprooting and the patient, the one being handed over this half-broken pot (rugio), may he be in love with them. If you hear we are fighting for goodness, this is what man fights for (he spits). A good person who is given to drink, if the throat is closed it opens. This time he will walk and there is no more of being told about kirumi (he spits). I have called you a good hand, I swear by all the oaths (he spits), there is nothing else, except this,I swear by all the oaths.'

After repeating many times this formula with empty hands, he repeats the action holding the little doll of muthigu; then he

does the same while holding the horns and using a spell that is a little different:

> 'You were bush herbs, I have called you muthega of kirumi, I swear by all the oaths. Thus I have called you, the muthega of kirumi, to be given to drink (he spits), to be given to drink even though asleep on the ground this way (he demonstrates), he sleeps once then he wakes up and talks. The good hand that is in love with the uprooter and the patient, thus I have called you, he who does not know the oaths. You were bush herbs, I have called muthega for kirumi.
> I bless you in a female way, this is a woman, the woman is the one with a bitter tongue and she is the one who has a quick kirumi. It is better a man, he blesses. I swear by all the oaths, I bless you with it. Even though she is a woman who has pronounced this kirumi, or a man, and I, being a man (he spits), it finishes by taking this muthega, the person recovers and what he was feeling it is finished (he spits). The good hand that is in love with the uprooter and the patient, Thus I have said (he spits). I have called you the real herbs, filled and good, never to bypass what you hear me telling you (he spits). You were bush herbs, I have called you the herbs for kirumi. To drink you feel better,yes, a person coughs, pushing up the cough, it jumps out and falls outside, and he talks about the way he was blocked (he spits). I have not called you muthega of anything else, I have called you the herbs of kirumi (he spits), I swear by the truth, do not eat for me and I do not eat for you, I swear by the truth, thus I have called you, the healing herbs (he spits). Even if the house falls there was no leaf, there was no child, by drinking this herbs, bitting a person. To be given you wake up. There is nothing present, there is nothing like being told about kirumi, there is nothing. Thus I have called you, I swear by all the oaths (he spits)'.

RITUAL OF THE GOAT'S HEAD

Once the blessing is over, M'Mburuki removes the muthega in form of mbiro (black powder) from the half-broken pot and puts it in a calabash, mixing in some water. Then he sits down and digs a small hole in the ground with the point of a horn; finally, he pours some medicine from the calabash inside the hole. At this point he calls the patient and asks her to sit down in front of

him, keeping the hole in the middle. Then he starts the proper ritual by reciting this spell:

> 'There is no kirumi, I have not left this (head) of a goat, we have put it in this hole. We put that of the owner, ourselves, we have put that of the owner of Njiru, we have put that of the owner of Kiiru, who have put that that was of the person who was of the house who had two umbilical cords. Let me spit from you, there is no more being told or even if you hear there is kirumi, there is nothing like recovering, only recover'.

Now M'Mburuki takes the goat's head and puts it on the hole; then he removes the tongue and puts it inside the hole. Finally, the hole is filled up with the medicine and the calabash with it is put on the top, to cover the hole. The mugao holds the patient at his left side and they kneel together next to the hole. He recites the spell:

> 'Even if it was that, even if you were brought by a person who brought you today, never to be told about kirumi, even of any kind, today. The child today is come to help kirumi, even of any kind, today. Even if you were brought by a man and a woman, even if it was of any person. Never to be told anything about kirumi, even if it is any kirumi, there is nothing. Vomit! Vomit!'

The patient is asked to spit away while the mugao recites the spell. Now they sit facing away back to back, keeping the hole in the middle. M'Mburuki continues:

> 'Vomit, vomit kirumi, vomit kirumi, never to be told about anything on kirumi, even if you come to bear what, never be told about it.
> I have come to treat you and throw away kirumi. No matter what, today, there is nothing like being told, no matter what. It was that of one who tells from the house, there is nothing, I come to make you vomit, to vomit kirumi.'

The patient was closing her eyes during the mugao's speech, while Rukungi was breaking some pieces of sticks and throwing them away. Now the mugao and the patient remain back to back but they stay kneeling, while M'Mburuki continues:

'Vomit, vomit child, that was of the back, child. I come to make you vomit kirumi, child, never to come to be told about it, child. Never to be told about kirumi, even if it that of a girl. Never to be told about it, never'.

Now they change their position again: the mugao and the patient sit down facing each other, joining their feet and always keeping the hole in the middle. M'Mburuki continues:

'Come to vomit that you go to collect on web-feet, that you went to collect yourself on your web-feet: I come to make you vomit that was of the mouth, that was the speaker, this was the one of kirumi. Never come to be told even what, never. I come to cleanse you kirumi, never come to be told even if of what kind. Even if it was the owner of Njeru or the owner of Njagi or of Chiamwene, Kiiru or of one who falls from a house. Today we have come to make you vomit, there is nothing like coming to be told about kirumi'.

Now they stand up facing each other and holding their hands, while M'Mburuki continues:

'Vomit, vomit the thing that was of kirumi. I have come to remove your kirumi, child, never come to be told about kirumi That was of relatives and clan, never. I come to cleanse, never come to be told about kango (spoken word), even of what kind, never. Never to come at night or day time, never to be told anything about kirumi of any kind. I come to cleanse you. Never'.

While they continue to hold their hands, they start filling the hole with soil. M'Mburuki continues:

'We come to bury kirumi, we bury kirumi child, we bury kirumi, we have come to bury it here. We bury kirumi, never, we bury kirumi'.

It is the conclusion of the ritual: they stand up and back to back they face away, holding their hands. In this position they complete the covering of the hole using their feet. When the work is done, they sit down on the hole in the same position (back to back, with hands joined) while M'Mburuki ends his spell:

'Let us sit on kirumi, let us sit on kirumi, let us sit on

kirumi (many times). Never. Let us move from kirumi.'

ADMINISTRATION OF THE MEDICINE

The mugao stands up while the patient remains sitting on the covered hole, waiting for the medicine. M'Mburuki takes the calabash and brings it near the patient's mouth. While holding it, he recites the formula:

> 'I come to give you to drink the herbs of kirumi, child, to give to a sick person to drink and he rises (he spits). Even if he feels stomach ache (he spits) or in the heart (he spits), to be given these herbs to drink, it is to cough and that cough that he has comes out (he spits).If it is a man, a child or cursed by a woman or a man (he spits), be it kirumi of food or kirumi of a goat (he spits)'.

M'Mburuki gives tha patient a sip of medicine; then he passes the calabash into the hands of Rukungi who recites his formula:

> 'Be it of food or of the goat, to drink is to rise (he spits).These are the good herbs you are united with. Even if it is kirumi of a man or of a woman. You were bush herbs: I have held you as the herbs of kirumi, to bless the muthega of kirumi, to give to a person to drink and he recovers. It happens he is healthy even if he was coughing or he is unable to walk with feet. You meet him holding and he removed: to drink is to purify this kirumi at once. You come to explain how you were feeling: there is no more coming again. Let me hand over to you the muthega for kirumi: to drink this muthega of kirumi, the illness even if it had filled the body migrates at night like the migration of ants, and gets lost with the wind like that. It spreads and you are left with a good body which can strike.
> I hand over to you muthega of kirumi (he spits), I hand over to you muthega of kirumi (many times). The good herbs of kirumi, to drink this muthega of kirumi (he spits). This kirumi migrates even though it is of a woman or it is of a man, or it is of a child, or it is of a person who had no child. To drink these herbs, it migrates (he spits)'.

Rukungi also gives the patient a sip of the medicine; then he passes the calabash to Kinyua to conclude the administration.

> 'The cough that blocked her is cleared. You hold good muthega, this you have held is good muthega, you are given,

to give to a person afflicted by kirumi to drink, the cough in the body recovers at once.
Be in love, feel to be children of one woman, to go to help the sick, the good herbs of kirumi.
Those who persist getting sick, you make them recover. You are united with it, you become the children of one woman'.

The patient drinks the medicine completely and then stands up. The ritual for kirumi is over.

4.11 Day X. 'Gendaga'

Monday, 15th December, 1986

The last reserve in the territory under the ugao jurisdiction before entering the large province of the urogi, is named gendaga. I had heard something about it, but I never had a chance to understand it properly. My master and his two assistants have promised me to fully satisfy my curiosity today.

Mburuki: 'Gendaga is when a person is made 'to eat an herb' (to get bad luck). The way it happens is when you are visited by a person in the morning and you are awakened by him or you just greet him, and then after that you experience bad luck on the road: you may be beaten by something and you are injured. That person is the one who has made you 'eat an herb', because there is a njau (totem) that does not agree with a person: it happens that your njau is different. The one who make you 'eat the herb' does not really want it, it happens that it is the njau that does not agree with you. He is a person of ntingo (bad family): it is that person who mentions something and it becomes bad.
To treat gendaga we use food because the thing a person eats is food, all types of food. All are eaten, for this reason gendaga is food. This name 'gendaga' originated from all types of food, that are eaten through the mouth. It is gendaga of food. These are not herbs uprooted in the bush. Because that person will make you eat gendaga, there is nothing he does not eat with his mouth.'

Kinyua: 'Gendaga is affected by a person with twins, a person with two umbilical cords, a person with a tongue pointing at somebody, a person with one short hand, a one eyed person and a kingu (evil person) and the njau that are called Njiru and Kiiru: these are the ones that could cause gendaga in a

person. Njiru is a bush buffalo and a very bad animal: because if you see a buffalo in the morning, that is a very bad luck.

M'Kamwara: 'What is a njau ?'

Rukungi: 'Njau depends on the way you give birth to a child, you call it a name. Njau is a baptism of a person, as you baptised a child and call it his 'njau', it is his particular njau. We are following our tradition. If your father was born as Njeru, know that the child you will give birth to be named after your father is Njeru. This is a baptism among Tharaka from time immemorial. A child who is born from the father, his njau being Njeru, that child is also born as Njeru. Njiru and Kiiru are considered bad njau, whereas Njeru and Nyaga are good ones'.

M'Kamwara: 'What happens to someone who contracts gendaga? '

Kinyua: 'A person who contracts gendaga sometimes could break a leg, fall from a tree or cut himself because of bad luck due to that gendaga'.

M'Mburuki: 'Or a person is abused by somebody else, a child dies, sometimes old goats die suddenly: these are all gendaga'.

M'Kamwara: 'Is there anything to prevent someone from getting gendaga?'

M'Mburuki: 'Yes, this protective charm (he shows a small bag): once we give it you, you use it and put it at the waist here (he demonstrates) or on the neck and go. It is not a horn,it is just a kabooro ka gendaga (small bag for gendaga) that is made: it hung after being used to treat gendaga, the muthega is put into that bag and you go with it. Afterwards, a person even if you are mentioned cannot transmit gendaga to you. Even people such as chiefs have these bags for gendaga hidden in their clothes.'

M'Kamwara: 'When one 'eats gendaga', how does one know?'

Kinyua: 'Only by going to the muringia (diviner). Nobody else is able to know. The muringia will tell you, if you have been affected by gendaga. The muringia knows because the mbugu (divining instrument) happens to be this side (he demonstrates): there is a side where it stands. Every divining instrument has its own stage: every stage that is mentioned to a person has a place where it stands. The mugao treats him. A person who is not a mugao cannot treat him , he does not know.'

4.12 Day XI. Ritual of 'Gendaga'

Monday, 22nd December, 1986

The road to Muthitwa is steep and narrow: we are driving there to Rukungi's homestead to be shown the ritual for Gendaga. M'Mburuki is ill and he has left the duty to his assistants: on the way we stop at Kibuka, where we collect Kinyua who will lead us there. The road does not reach the spot: from where we leave the vehicle, we have to walk for about half a kilometre to climb a stony hill. Rukungi is already at work, preparing the muthega for gendaga. This time there is no real patient, and his wife will act as such.

BLESSING OF THE MEDICINE

First of all, Rukungi shows me all the contents of the muthega: there is millet, finger millet, sorghum, pumpkins, greengrams, cowpeas, maize, pigeon peas, capsicum, honey and milk: all foods that are eaten by the people - he says - plus muthuri, a plant that produces latex. They are all taken, grounded and dried. Now the muthega is ready for blessing. But before he shows me the horn for gendaga he has prepared for me: it is a small he-goat horn, he has prepared it using a piece of red-hot wood to file the edge.He tells me he will use it to bless the muthega for gendaga. He takes the pot containing it, puts it on the ground and sits down in front of it; he marks himself and the pot with iraa in the usual way,then he takes the gendaga horn he has prepared together with mitimikuru and mpau ya kindaji (small gourd) from his kiondo and starts blessing the muthega,

making several semicircles with them, first clockwise and then anti-clockwise, while he recites the following spell:

> 'Even if it is gendaga he has eaten, never come to be told about it. If you come to be told you ate gendaga, to be made to vomit and be given this muthega which is here.
> I have called you muthega of gendaga, the good one (he spits), never to eat gendaga , thus I have called you, I swear by all the oaths. Never bypass with this that you hear me telling you and if you hear we are talking. To treat it, never come to be told about it, I swear by all all the oaths.
> You were bush herbs, I am rejuvenating you because of this horns I was blessing this way. Be in love with M'Kamwara, to become a good thing. Even if you come to hear to be told about it far away or in the home (he spits).
> I have called you the cleanser, shhhh.... (he breathes out), truth and breath, this gendaga, never, I swear by all the oaths (he spits), never to bypass this herb, I swear by all the oaths'.

RITUAL OF THE FIREPLACE

Afterwards, Rukungi goes to the fireplace and places the pot on the three stones used for cooking: he kneels down and passes the pot through the three stones , meaning to remove gendaga. Then he calls his wife, making her sitting down with her legs outstretched near the fireplace. He pours the muthega from the pot into a calabash, adding some water to make it liquid; then he holds it in his right hand together with the nkio (flywhisk), while with the other hand he picks up the mukua (needle), the kajiu (knife), a stone (like that used as a mortar on the grinding stone), the small horn for gendaga, mpau ya kindaji,and two cooking sticks, muurugo (wooden ladle) and giiko (frying spoon). With all these things in his hands, he moves around the 'stand-in' patient, stands at her back, then he passes his hands under her armpits while he says:

'Vomit gendaga, let me remove now (he spits). I remove from you what you were brought. Vomit gendaga, move away.
I have come to remove from you gendaga of the owner of Njeru,
I have come to remove from you gendaga of the owner of Njagi.
I have come to remove your gendaga that was from the back of the home (he spits).'

He runs away westwards and comes back to the patient running; he moves his arms with all the objects in his hands all along the patient's body and then stretches them towards the sunset, pretending to throw something away.

'Vomit gendaga, vomit what you were brought. Let me move away gendaga, let me move away from you gendaga: now son, let me come, this is how gendaga came. I am sure, so gendaga came with him this way.'

He runs away eastwards and comes back to the patient:he asks her to touch the tools in his hands with the tip of her tongue, alternating the movement of the two hands while he repeats:

'Let me come and remove from you gendaga, so this is how it came, now I remove away from you gendaga, so this is the way it came'.

He goes at the back of the patient and turns his back to her: then, back to back, he recites this spell:

'So it was brought, vomit the one that came from the back. that which was for the legs. Let me bring to you gendaga, so it was coming like this, vomit gendaga now, you vomit the first one and vomit the last one.
Vomit the one that was from a woman with two umbilical cords, I remove away gendaga.
Vomit the one that was from the owner of Njagi, from the owner of Njoe, from the owner of Njiru: vomit the gendaga you were brought.
I have come to remove from you gendaga, to remove gendaga of twins, gendaga of one eyed person.
I have come to remove from you gendaga from a person who has one hand, I have come to remove from you gendaga of the left (hand).
I have come to remove from you gendaga of a scare.
Let me remove gendaga from you, let me remove from you completely gendaga. Vomit, I come'

The patient is asked to raise her arms, while he moves his arms under her armpits repeating:

'Raise, I remove from you gendaga: so you were brought, like this, from the bottom without you knowing. That gendaga now I remove, I remove gendaga.'

Now he runs away to the gate of the compound, pretending to throw out something:

'Let me give you gendaga, let me give you gendaga, let me give you gendaga (many times)'.

Finally, he puts on the ground all the objects he was holding in his hands apart from the calabash with the muthega, which he gives to the patient three times with a sweeping movement up from feet to mouth. Then he also takes a sip, he gives to the patient to drink for the last time and finally pours some of the contents on her back, passing it over her head while repeating:

'Let me give you gendaga, drink sweetness (many times).
Let me make you vomit gendaga, son.
Let me make you drink gendaga, drink sweetness.'

4.13 Day XII. 'Urogi'

Monday, 29th December, 1986

My trip into the Ugao jurisdiction has reached its core: the urogi. The fundamental ambivalence of the ugao's knowledge is evident here:the mugao must know how to make black magic (kuroga) in order to cure it (kurogora). This also adds to the ambivalence of the Ugao's power, which can be used for either beneficial or evil goals. Today my master and his two assistants will lead me to tackle properly this issue, giving me a detailed explanation of it.

M'Mburuki: 'Urogi means to uproot herbs and bewitch to harm a

person: it is performed during a moonless night in the bush by the naked murogi (sorcerer). A mugao is taught how to bewitch (kuroga) and to cure bewitchment (kurogora) at the same time. He is instructed not to use this knowledge to bewitch for nothing, unless under certain conditions. Therefore, he takes an oath (muma) on this issue not to kill people without an approved reason. The oath is to prove that one will not use one's knowledge to kill people but to cure them. An oath is really higly respected, according to our customs; but if somebody has stolen your property (for example, the honey from your beehives), you will announce it for a period of seven days. If the stolen property has not returned after the seventh day, the mugao has a right to bewitch whoever stole the property.

Usually arogi (plural of murogi) do not like to see those people they have bewitched being treated, they like them to die instead. So we are very careful at this point of treatment, to see if the patient has recovered completely. A murogi may poison a patient again.

Usually a murogi who has bewitched a person cannot cure him in any case whatsoever. After urogi, he warns other agao not to treat the person. But sometimes, if the murogi talks with a mugao and they agree, the treatment for bewitchment can be carried out to help the patient. In this case the person may survive. When a person survives, he is warned not to repeat his mistake again, for example, if he has stolen one's property.

Urogi happens when people have offended one another. Usually, we refuse under certain conditions: for example, when one is our relative. Afterwards, people usually go to another mugao who will make it.

A murogi bewitches with seven magical objects. To counteract bewitchment, the mugao uses the numeral seven to tackle the numeral seven used for bewitching. This numeral seven is marked on the arm and on the leg in two colours: red and white.

A mugao has two types of horns: one type is used to bewitch and the other type is used to treat bewitchment. The mugao must repeat the bewitchment during his treatment in order to attempt to know what numeral among the seven was used to bewitch.

The murogi, when he is bewitching, uses biama (sorcery). These are removed by the mugao when treating a person. Even the mugao, when treating, calls them biama, as well as the murogi, because it is a kiama that he does saying, 'May he/she die that way'. If a mugao happens not to know these biama well, he cannot treat a person and get him to recover.

M'Kamwara: 'What types of urogi are there ?'

Kinyua: 'True uroqi are mero and mpingo. True uroqi is mubarukio. True urogi, from time immemorial, is that of putting rurigi (string) on the road. Also kio is uroqi, and there is that other of making a person being beaten by a snake, putting a nkou (lizard) on the buttocks. Finally, there is also

uthuki, which means to remove objects put in the body.
For mero I mean an immediate killing: a very serious poison is given to an individual, normally through food or drinks. One starts to swell in the throat with stomach ache: the throat becomes so swollen that one is unable to swallow food and he cannot talk. That is the effect of mero.
By mpingo I mean when someone has been bewitched either by crossing a poison on the way or has been given poisoned things to drink from a container, for example a cup. Mpingo is also commonly used to prevent thieves from stealing honey from the beehives.Mpingo also makes one not able to eat food for a long time. It also means stopping a person from his normal activities for a long period: if she is a woman, she becomes unable to have children until she is treated.
Mubarukio affects women generally: they experience fits and faint with foam coming from their mouths. Rurigi is also generally for women: it is when one is made to pass over a string on the way so that she falls in love with a person she does not love. Or sometimes a person may hate someone and make him/her pass over rurigi.
For Kio,for example, you are sitting here and I collect soil from your footprints; then I collect your urine, your saliva, the nails from your hands and feet. Then I wrap them with leaves and place them somewhere in the ground. This is what is called kio: it is usually done not to allow a woman to give birth, and if she is pregnant she miscarries.

4.14 Day XIII. The Case of Ndeke: 'Uringia'

Monday, 12th January, 1987

Ndeke is a 35 year-old man with a good level of instruction: he received Secondary Education and then was employed as a Primary School teacher. He is not a Tharaka: he came to Nkubu Hospital one day from Chuka, asking for help because of his problem. But the doctors there were unable to help him: the diagnosis was 'male impotence, probably of psycho-somatic origin'. Therefore, they suggested that I take Ndeke to a Tharaka mugao and observe what happens. Since my master had requested me for a real case on which to practise their teaching, I took the chance and I proposed to Ndeke that he

be referred to those agao. Being a Chuka person, and with a certain level of education, he had immediately showed some scepticism at the proposal; but then, after I explained to him at length the meaning of the work I was doing, he seemed to trust me and he agreed. He was also well aware of the fact that no one in Chuka or Nkubu Hospital had been able to cure him; and he also knew the reputation of Tharaka agao.

THE QUESTIONING OF THE PATIENT

When we reach the usual tamarind tree together, the three agao are already at work. While M'Mburuki and Kinyua continue with the preparation of the medicine, Rukungi sits down with the patient questioning him about his problem.

Rukungi: 'What do you feel, where do you feel pain in your body?'

Ndeke: 'Not that I am sick, when I am alone I feel a desire for a woman, and I wish her fully. But when I get her and we go to sleep together, my desire for her disappears and I am completely unable to erect properly. It happens that my penis does not erect well.'

Rukungi: 'Have you a wife?'

Ndeke: 'I have no wife.'

Rukungi: 'Did you experience this in the past, did you feel a desire for a woman, to go to a woman and feel well (erect)?

Ndeke: 'I felt a desire when we were boys, as boys do. But since I was circumcised, I used to go (with a woman) and the desire disappeared once I slept with her.'

Rukungi: 'Is it a long time ago or recently ?'

Ndeke: 'I was circumcised in 1966, December.'

Rukungi: 'Do you feel badly ?'

Ndeke: 'Yes, I do.'

Rukungi: 'Did you go to other agao?'

Ndeke: 'No, only to the hospitals.'

Rukungi: 'After going to the hospitals, you still do not feel you are recovering?'

Ndeke: 'Yes, I do not feel I am recovering.'

THE STORY OF NDEKE

In the meanwhile,Kinyua was preparing the mbugu (instrument) for uringia, the divination. When it is put on the ground,he says that he cannot divine immediately because it is noon.

Kinyua: 'Let us wait for the time of divination to come: let us wait until 6 p.m..'

We sit down all together in the shade of the tamarind. Kinyua goes home and comes back with some cooked eggs which he offered us: while eating, I ask Ndeke to tell more of his story. He agrees.

Ndeke: 'The first time I realized my problem was early in the 1970s: from then I realized I was unable to meet a girl. It was during my Secondary Education. There were many girls during my school time who wanted to make friends: I had many. I tried to meet with girls, but there was no reaction. At first, I was thinking there was something during my circumcision time which made me go wrong:because during that time, according to our tradition, one can be made by the circumciser or someone else to remain without having a wife. Even my young brothers, when they had to be circumcised, I refused to let them go to the local circumciser, because I feared we could get lost the all of us. Since I was the eldest brother, I told them, 'If you refuse to go to the hospital, you will remain like that' So they went to the hospital.
Afterwards, I tried to go to the hospital: the first time I went to Nkubu hospital, that was in 1974. The Italian doctor who was there examined me: he saw some parts which were swollen in the low abdomen, and he told me that before treating my problem he would have treated those swollen parts. I was given ten injections of penicillin. After that, when I went to Nkubu again, the doctor who treated me had gone away: so I stayed like that for some years.
Later, in 1978, I tried to go to Nyeri Hospital (Central Province): I went there, but because of my fear I did not explain myself to the doctors properly: sometimes there are people or nurses in that hospital from our area, who could

spread the matter. So when I went there I was admitted for the cold and I stayed for three weeks.Before I left, I tried to see the nurse in charge of the sperm test: but she had gone on leave.I was given some tablets: when I came back and took them, there was no reaction. Later on, I went again to Nyeri and I met a doctor who told me to take the sperm test; but in the place where I went to sleep, I did not produce any sperm.

Before going to Nyeri, I had explained that matter to my relatives, people of my clan: I told them, 'I want to go to the local healer'. Since some of them are strongly converted to Christianity, they answered me, 'Your father was not in touch with this local healer, so we would not like you bring such a shame on our clan'.

When I came back from Nyeri, I remained for quite some time wondering, 'Am I going to get lost or what?' There was a doctor who comes round our area from Kyeni (Embu District), a Dutch man: I explained him my problem and he prescribed me some tablets. When I used them, there was a very serious reaction. But when I was given them, the son of my step-father had a problem with his wife, who was admitted in the hospital. So he called a sister of that wife to come and stay with his children and because he had got one house only, he came and borrowed from me a bed to sleep on. Therefore, I was unable to look for a woman to sleep with.

After those tablets finished,I tried to go to Kyeni Hospital to look for the same tablets: but the doctor I had met gave me some tablets of a different colour which I took with no reaction. After a week, I went back to Kyeni: the doctor told me 'There is another doctor in Nkubu, would you like to see him?' I replied, 'Now, given the stage I have reached, I am ready to go anywhere'.

That is when I came to Nkubu Hospital; in the meanwhile, I was sacked from my job, together with some other untrained teachers; but whereas my colleagues tried to get re-employed, I thought there was no need to go back because of my problem. When I was teaching, those who knew I was not married, were laughing at me, especially when I was teaching about the reproductive system.'

THE DIVINATION

Sitting on a big stone near the tamarind tree, Kinyua marks his right eye and the mbuqu with iraa. He uses two instruments to divine: some snuff and a glass pipe with some liquid inside and two floating objects in it. He begins by asking the patient to put some snuff on his right palm ; then with the left hand he takes the glass pipe and starts the divination looking at the

objects in his hands and talking with the patient, after whispering a short prayer.

Kinyua: 'Tell me your name, the one you were called when you were young by your mother and father because you have no wife.'

Ndeke: 'I am called Ndeke, son of my father Irauka and of my mother Mwanaeri.'

Kinyua: 'Ndeke, you are under the bed of Irauka, in the middle of the bed with Mwanaeri (he spits). I am requesting peace for you between now, Okongo and Nyamwezi of Njudia of this edge of the moon, I swear by all the truths where they stand (he spits). What is maliciously pointing to you 'Ndeke will become', this is what is holding you, this is what I want to clear here, like how a leaf makes itself clear on the tree in the seventh month. It cannot get the strength to return to that very tree (he spits), as water rains and passes (he spits), I swear by all the truths, it should not return back again (he spits).
Ndeke, you are your parents' lamb, what affects you and makes you lacking eggs? This is what I want to become clear, I swear by all the oaths. If it happens to be bewitchment of mpingo, or things of kirumi, or urogi of kibitana of death (he spits), or things about kibitana of circumcision (he spits). Let it come clear (he clears the throat), let it come clear (he clears the throat).
Listen to your mbugu (divining instruments). During this time (he describes what he sees), it is like a home built by two people in your place during a very long time. A sudden death, sudden, that follows: do you know it? In a year, one out of two people goes out of the home dying. Time, you will stay as if you were staying in a place with many iron sheets, in town or at school, I do not know, in the field. I do not see you were staying under the eaves in the home , I mean in a period of three or five months, another person dies. I do not say tomorrow or the day after tomorrow. One looks as if it was a child and the other an adult.'

Ndeke: 'There is no one I see.'

Kinyua: 'Is there anyone you can see at all?'

Ndeke: 'No, I do not.'

Kinyua: 'It happened that this person seemed as if he had a field, as a relative or you were staying with him?'

Ndeke: 'In a place with a field?'

Kinyua: 'Yes, in a place where there was a slope and the other side was climbing. In a place with trees like a forest.'

Ndeke: 'There is no one I can see.'

They seem to disagree on the findings of the divination: the mugao looks a bit vexed whereas the patient shows a sort of passive resistence not to accept the findings. The mugao repeats the divination, continuing to manipulate his instruments to get more information.

Kinyua: 'What is stopping Ndeke? (he spits). Ndeke is completely disagreeing (he spits). Ndeke is refusing (he spits). Where? Where is the problem holding him? (he clears the throat).
Ndeke,the journey you went to a place with those iron sheets and seeing the forest as we are seeing those trees (he points somewhere),there is evil from a person who died there related to you, of your family; if he is not of your family it happens that you were staying with him. Were you staying with him? If you do not see him, do not say you see him, but you are there. A black man, who was not brown completely, a black man, black. He was buried nearby in a place with trees, seeing the road near as we see that (he points at the track). He did not die in a hospital, it was at home: when he died, he was put in a common burial place. And this is the time your evil started.
Before you started this evil,was there a time you were urinating and you felt some kiumago (pain while urinating) for the first time, cha cha cha, burning because of pain? do you remember that time? '

Ndeke: 'I do not remember that time'.

Kinyua: 'There is no time you urinated and you felt burning? Is there any time you felt the umbilical cord as if it was pulling itself? feeling something like stomach ache, feeling like cold?'

Ndeke: 'There is no time.'

The mugao looks very annoyed and dissatisfied and complained to the patient whether what he was replying was true. Possibly, a gnawing question starts troubling his mind: 'Is the white man trying to test me through this man?'. Kinyua does not show any sign and continues the divination for the third time, since the first two seemed unsuccessful.

Kinyua: 'When will you refuse his problem? Where is it, I kill a

goat for you, I swear by all the oaths (he spits). I want light, that light that clear darkness. That is what I want, to chase this evil that is in your body, Ndeke (he spits). That is the problem of Ndeke, he is refusing, that is it completely (he spits), insist on him completely (he spits): if you are speaking a lie, you will be ignorant of that oath by which we were joined with you. If I come to speak a lie to it, you also return (he spits). That is truly the problem of Ndeke, what problem? (he spits, making a long pause)...
This place you do not see, a place a person died with you, a place you will stay as if you are beating with a building on the other side (South) and this other (North). There a foot in a place that looks like descending, that is you were staying with him, with that person.

Ndeke: 'Not unless one while in school, we stayed with him in school when we were boys. There is a person we were staying with : we met in school and even went to his home, but I never knew how his death came when we were still boys.'

Kinyua: 'Had you strong friendship?'

Ndeke: 'Still as boys. But even his death, even his burial, I cannot say how he was buried.'

Kinyua: 'Was he black? because here (he looks at the glass pipe), I can see a black person ?'

Ndeke: 'Yes, he was a black person.'

Kinyua: 'Was he staying in a place looking as if there was a field, be it in town or in school, I do not know? Did you see him being buried? Like that road? Did he not die in a hospital?

The last questions were not for Ndeke but for the divining instrument: after they finally seem to agree on something, the mugao looks carefully at it to concentrate on this friend of Ndeke who died when they were still boys and discover something else.

Kinyua: 'The problem of this person (he spits),is it the one that has affected Ndeke (he spits) or did he cause it? Where has his problem come from? Where has the problem of Ndeke come from really? (He makes another long pause, before giving the results)...
Do you see your divining instrument is speaking well? That is, you are refusing to side with the divination. It seems that you were bewitched being two people: one person died, the black one, the one I was telling you about. He was

buried while you were seeing on the road there. And this time, as you are telling me, were you feeling something at your waist? As if it was aching, feeling like pea pea pea: unless you tell me that you are forgetting. Like when a person is able to do something evil but he is frightened when he remembers, you reach a time you are frightened like that. You may stay and feel as if fear is frightening you, the heart starts to beat du du du du du, do you feel that?'

Ndeke: 'Yes, in sleep, when I am in sleep'.

Kinyua: 'The only son is only Njeru, who is born alone being a man or a girl: is it you or your father or who else?'

Ndeke: 'It is my father'.

Kinyua: '(Looking at the glass pipe) And these two cases he had: do you know them? A case and a case: twice'.

Ndeke: 'For what and what is it?'

Kinyua: '(He spits) These two cases (he spits) ... for what? (he spits). What were they disputing about? (he spits). What were they really disputing about? This only son was disputing for what? (he spits). Were they about land? Do you see it? ... (another long pause before giving the results). It was your father who was being killed because of disputing over the land, he is the one who was being killed. Have you understood? You were bewitched with a type of string passing over the road (ruriqi). This place looks as if there was red soil, you descended and emerged uphill there, like that one (he points to the top of a hill). And you see another home uphill there, a place like this one, that looks as if there was a bench and a heap of soil. You used to come there and this evil came from there and it is the one that killed the other person. You need to be treated well for urogi: this urogi came from the dispute of your father over the land with this two people thet were disputing with. They were bewitched being two children, and one black person does not seem to have been a friend, he seems that they were intimately related as if they were one thing.
He is not there, he died, he was killed by the illness of the stomach: he suffered from a kind of stomach ache, he was given water and started vomiting. He did not die in the village: he fell on the road, that is where he died looking like a person who was being taken to the hospital.
This (Ndeke) is also leaving with his heart not relaxed at night, sleeping and feeling as if a person has done something very bad. He is frightened and the heart is changed. He feels this when the moon is in this (direction). And this only son is the one who is being followed so that his strength is finished, your father.
And your sister, when she had a child, she delivered the child with great problems. She was sick for three days and she delivered the child with great problems. She is from

your home, not unless she tells me the home was built big together with your uncle and lived there because I see the camp of the home. Also in the home there is a person who was suffering there: it seems that his eyes were not powerful. Do you see him?'

Ndeke: 'Unless my mother'.

Kinyua: 'Do you hear her telling you she is suffering from this type of sickness?'

Ndeke: 'Yes'.

This time the mugao seems really satisfied with the results and started talking with me, explaining the way he looks at his divining instruments and interprets the signs. Ndeke looks a bit disappointed of what he has just been told by the mugao, as if he had lost his former mask. His head is bent on his right shoulder, while his blank look denotes an interior torment. Kinyua concludes his divination by trying to formulate a sort of prognosis.

Kinyua: 'He will be treated completely. Add this snuff (he spits), he will be treated completely (he spits): even this sorcery of mpingo will be removed from him. He will be treated completely while he is being handled by the agao (he spits): then, he will recover completely (he spits). That is when he will be able to prepare food for the relatives and the clan (he spits), to have posterity and a wife, like a banana that is surrounded by its snatchers not to be separated by any other banana (he spits).
Let them run on their feet and hands like a monkey, an animal of the bush, as it has no mugiro (he spits): then he will be well (he spits). Once Ndeke is treated, he will then be really well (he spits). That is when he will be well'.

Then he looks at me and explains the way he has reached such prognosis pointing to the bubble inside the bottle:

Kinyua:'Can you see these air bubbles? One of these does not fit: it is not good, it is not holding, it stays in one place without melting. It is near to melt and once it is completely finished, you stop seeing it'.

4.15 Day XIV. The Case of Ndeke: Ritual of 'Rurigi'

Tuesday, 13th January, 1987

The second day the agao are ready to start the treatment of Ndeke: they will try in different ways, since they consider this a difficult case. The first treatment is the ritual called rurigi (magic string). Kinyua has taken the horns out of his kiondo and put them in the half-broken pot called rugio together with the kioria (medicine) he had first prepared. Then he starts blessing them by reciting the following spell:

> 'Njeru, as you come from the source (he spits) going to your place, to the relatives of your mother and father (he spits), go with migiro (impurities) and leave us with trills. I swear by all the truths, good horns (he spits) which are not mentioned. As we come to suck you multiply this way (he spits) since you will face the bodies of people. I swear by all the oaths, you are children of one woman, there is no fight (he spits). They are of oil, they are of good smell, they are of a good smell tree (he spits). Let us care each other (he spits), to treat a person you awaken , I swear by all the truths, to walk on ten toes (he spits), to prepare food for relatives and the clan (he spits). Let us have trills, karirririririri... (he spits), karirririririri... (he spits), four trills for boys and girls (he spits). Going out you feel he is walking with ten toes and work for himself with the legs and the hands like a monkey, a bush animal that has no mugiro. They are nyambura (goodness), I need them, we give a gourd of beer and we give you honey...'.

While he pronounces the last words, Kinyua sprays a mouthful of water over the horns to bless them. Then he continues:

> 'I swear by all the oaths (he spits), to raise the sick and walk like a great walk, they preserve thanks and they remember (he spits).
> You will be producing as a mugao and a wife of a mugao. This is our gourd of beer we have been offered and there is nothing else that has been offered to us, I swear by all the oaths (he sprays another mouthful of water over the horns). Good horns, which I have handled, that have the owner and the patient, I swear by all the oaths. We shall be laughing like children when they are at home happily listening to the boiling pot on the fire. They will be trotting, those that favour the owner, I swear by all the oaths, to favour the

good, they bring goodness home. I want goodness, I curse evil (he spits on the horns)'.

Now Rukungi takes over the role of Kinyua and ends the blessing of the horns.

'You are being offered honey and also meat: they beat a person and it happens that the person is bad like a penis that produces for a person. To be touched with these horns is to meet that, it is the penis that it is erecting, nka nka nka ... he gives birth to boys and girls, they are born. We are offering you meat also. Now I am offering you honey, I have offered you pure water, I have offered you honey, let us be united to be one person (he spits) which unites together and the hands love each other'.

BLESSING OF THE MEDICINE

After completing the blessing of the horns and of the medicine together in order to combine their efforts, now Rukungi continues the work by blessing the kioria separately.

'I have called you kioria to heal muthega (sorcery) in the body, be it of nyanjo, be it of ruriqi, be it of itemekia, be it of kibitana (types of sorceries). I have called you kioria, I have not called you muthega of uroqi, I have called you kioria, the kioria to heal muthega in the body. Even if it is of Taita, or of Kamba, or of goose, or of metal. To be touched with this kioria, is to weather as the leaves of trees weather when it is hot (he spits).
I have called you kioria, get up kioria (many times), do not be left behind by muthega (he spits continously). I have called you kioria, do not be left behind by muthega as the dog is left behind by the monkey (he spits continously). To be touched with this kioria, the muthega migrates, to be touched is to become water,is to become a puddle of the road (he spits). Get up kioria, get up kioria, do not be left behind by muthega, iiiii... (he screams).
You were bush herbs, now I have called you kioria to heal muthega in the body. To be touched with this kioria is to migrate that very hour, that very moment you are touched with it. It is to disappear as the dew on the track disappears once touched by a person walking on it (he spits continously). I have called you kioria to heal muthega in the body, even though it is a type of kio or mpingo. Even though it is kibitana or muthega of nyanjo, or of the night (he spits). All the biama (sorceries) are only these here, even the water of the sea is also here. All the biama, even those of the sea. With this kioria, even though it is muthega of ruriqi or it is muthega of uroqi: to be touched

with this kioria is to migrate like the migration of bees, or the water of Thingithu (river) that changes into lakes (he spits). Get up kioria, get up kioria (many times while spitting continously). There is no biama, all the biama are here (he spits). Even the leg of the monkey or even the foot of man is here (he spits). Get up kioria, get up kioria. I call you kioria, you were bush herbs but I have called you kioria to heal muthega in the body, I have not called you bad muthega. I have called you kioria: muthega touched with this kioria migrates at night (he spits)'.

THE RITUAL

Ndeke, who was keeping himself aloof observing everything during this time, is now called in order to start the treatment of rurigi by M'Mburuki. The latter gets out from his kiondo two different instruments: the rurigi (a string with seven knots and some small sticks, each marked with seven notches, hanging from the ends) and a bow with arrows (uta and migwi) in miniature. The mugao traces seven parallel marks over the ground using the point of the horn for rurigi; then he buries there the rurigi together with the bow and arrows in miniature. At this point the patient is asked to come and step over it using his right leg first, meaning the bewitching. Then he repeats the same action from the back, meaning re-bewitching or counter-action. Finally, M'Mburuki disinters the rurigi and puts it above ground in a semi-circle, meaning the delimitation of the treatment area. Where the opening is left (meaning the entrance), the needle and the knife are dug at the two ends of the rurigi.

Ndeke is asked to pass through the opening and sit down in the semi-circle with the legs stretched and holding a razor blade in his hands. M'Mburuki starts by blessing the patient using the nkio (flywhisk) to touch all his joints and head; then

he smears some kioria on his palms and claps his hands over the patient's head; finally, he moves his hands in the air as though he is sweeping something away. After this, he moves his left leg over the patient's head making some semicircles; then he repeats the same action using his right leg. At the same time, he pretends to pierce the patient with the knife at the head, the neck and the back, after facing the patient holding the knife by the blade; he repeats the same action while holding the knife by the handle. Finally, with the knife in his hands, he runs away towards the sunset and pierces the air in the direction of the sun while shouting, 'Go away, go away!'.

When he comes back, he steps over the patient; then, holding the knife with one hand, he imitates masturbation with the other hand around the blade. Next, he steps over the patient again from the back and whispers some words in the patient's ear, 'This is the only kiama (sorcery), there is no other'. At the end, he whisks the flywhisk at the patient; then he dips it into the calabash containing the kioria mixed with water and sprinkles the different parts of the patient's body many times with the solution.

At this point M'Mburuki calls Kinyua and asks him to collect some small stones which he drops as he counts the number of rounds he makes around the patient. Then he starts making seven circles clockwise, dropping a stone at the end of each, while he repeats the formula:

'I have come to bewitch you (he spits), I have come to bewitch you (many times), you were bewitched with muthega in the pot (he spits), I have come to bewitch you, the horns were put in the waist (he spits), I have come to bewitch you'.

Then he stops in front of the patient and starts making seven semicircles in the opposite direction, continuing dropping the stones while he repeats a different formula:

> 'I have come to rebewitch you (he spits), I have come today to rebewitch you (many times), I have come to make reverse the <u>rurigi</u> (he spits), I have come to remove from you <u>rurigi</u> (he spits). You were bewitched with horns by that Kamba, I have come to rebewitch you (many times)'.

When he stops, he is given a walking stick by Kinyua and starts moving around the patient with it, repeating a similar formula:

> 'I have come to rebewitch you (he spits), I have come to rebewitch you (many times). There is no sorcery, it is dew, may it disappear like the dew of the road (he spits), to raise, like the body raises (he spits), the body that becomes well warm in the way <u>Murungu</u> (God) created you. Be held by the woman you had sex with and she delivered a child (he spits). The sorcery is dew, the sorcery is only that, there is no other'.

He dips again the flywhisk in the calabash with <u>kioria</u> and whisks it at the patient; then he picks up the calabash and takes a sip of the contents to spray the patient with, first his body, then between his legs and, finally, to the four cardinal points. Next he pretends to faint while bending and lifting his legs a little. Then he repeats the clapping over the patient's head while pretending to sweep something away; furthermore, he holds the patient's head and bangs it with his own. Then he pretends again to pierce the patient with the knife on the head, the neck, the back, the umbilical cord and all the joints. Finally, he tells the patient to rise up holding the horn point. Ndeke rises up and stands while the <u>rurigi</u> is removed from the ground; the remaining contents of the calabash are given him to drink.

4.16 Day XV. The Case of Ndeke: Ritual of 'Kio'

Wednesday, 14th January, 1987

The treatment of Ndeke continues with the ritual of kio: the first phase of it started the day before with the preparation of bio (bundles) and the operation of binding; and it continues today with the unbinding and the blessing of the patient. This is because time is considered an important factor in this ritual: my master, in fact, explains to me that the binding must be performed at sunset and lasts all night long, whilst the second part (the unbinding) is performed the following day at dawn.

THE BINDING

Rukungi prepares seven strips of equal length using the tree leaves called magombogombwe; in the meantime, the patient is made to sit in front of him and asked to give him seven pieces of different parts of his body. Consequently, he removes seven pieces of finger and toe nails, of hair, of armpit hair and pubic hair, and spits some saliva seven times. Then the patient is asked to go into the bush and urinate to collect some drops of his urine on a strip. When he comes back, the mugao also tells him to press his footprint on the ground, and picks up seven parts of the pressed soil. Next, he rolls up the strips and binds them up with the bark of muragwa.Then he puts the seven bundles in the usual half-broken pot (rugio); he takes three horns and holding them in his right hand he draws seven full circles anti-clockwise over the pot while he recites the formula

of bewitching:

> 'I have come to tie you the kio you were tied. What is your name? (The patient replies, 'I am called Ndeke' and he continues). I have come to tie Ndeke as he was tied by the murogi who tied him so as not to have a child or have a wife. I have come to tie you today (he spits). I have come to tie him kio (he spits), I have come to tie him the pubic hair so as not to have a wife or have a child (he spits). I have come to tie him (many times).
> Therefore, that is how you were tied (he spits). I have come to tie you so that you may not have a child, so that murogi tied him this way. I have come to tie you today (many times). Therefore, that is how you were tied by the murogi, the murogi, he is the one who came to tie you: but today, I have also tied you (he spits). I have come to tie you, I have come to tie you the way you were tied by the murogi. I have come to tie you kio, that is what I have come to tie you (many times).
> Therefore, that is how you were tied, just like that by the murogi so that you may not have a child or you may not erect (he spits). I have come to tie you today, I have come to tie you (he spits). Even if it is a woman who tied you, or a man, with no child (he spits). I have come to tie you today (he spits)'.

THE BURYING

Afterwards, Rukungi collects the seven bundles from the pot and a horn and goes to bury them in different places: underground near the treatment area, on the pathway, in the bush, upon the tamarind tree branches and under its roots. While he does this work using the horn point, he repeats the following formula:

> 'Kio, I have come to bury you in the earth, I have come to bury you. That is how you were tied and you came to be buried in the earth as kio; kio, as you were tied.
> Therefore, you were tied and covered under a stone. I have come to tie you because you were tied on the path, you were tied on the path. I have come to bury you under a tree root. Therefore, it is under a tree you were tied and dug into the earth. You were put on a tree, so you were put over the branches of a tree. There, I have come to tie you, to dig you into the earth here. Therefore, this is where you were tied and put. Even if it is kio that you were tied with (he spits)'.

The binding is finished: it will last all the night long,

while the patient will be sleeping. We move all together to Kinyua's homestead, where we shall take supper and sleep. We sit down around the fireplace, together with some curious neighbours: the bush is plunged into the darkness of a moonless night and we have supper chatting about this and that.

THE UNBINDING

At dawn on the following day M'Mburuki, helped by Kinyua, prepares some kioria mixed with water in the calabash. Then he takes a horn and goes to the places where Rukungi had hidden the seven bio the day before, followed by Kinyua holding the calabash. Following the same order, he stops at every spot, he asks Kinyua to pour some medicine from the calabash and digs up the kio using the horn point. While drawing the bundle out, he recites the following formula:

> 'There, on the branches of a tree, that is where I have come to dig you up today. I have come to dig you up where kio was dug for you (he spits). I have come to uproot you, it is here where you were dug, here at the middle of the field, it is here, I have come to remove you today. Even if you were tied the eggs not to come to touch the stomach. There is nothing, it is cold, it is dew. Even if you were tied with a globe, there is nothing, it is cold it is dew'.

Once he has gathered the seven bundles, M'Mburuki put them in the calabash containing the kioria and, holding the horn, he draws seven semicircles clockwise over them. Then he starts untying the seven bundles while he recites the following spell:

'I have come to remove you kio that you were tied. I have come to remove kio (many times). I have come to remove kio for you today, that you were tied by a person who had no eyes (he spits). It is kio which I have come to remove. I have come to remove kio today which you were tied with by those arogi. To touch a woman with penis, there is nothing. The penis that does not become flabby and strikes like bees

in a beehive. It becomes a penis that swells like a river to give birth to boys and girls (he spits).
I have come to remove kio which you were tied by that murogi, there is nothing. I have come to remove kio (many times). Healthy body that swells like that of other men (he spits). There is nothing, it is cold, it is dew.
Even if it is this kio, today, I have come to remove it completely (he spits), I have come to remove you kio completely, that is what I have come to remove you today (many times). There is nothing, it is cold, it is dew. It is migration of ants, this penis that erects to touch a woman, if she has to conceive and produce boys and girls'.

Finally the mugao asks the patient to sit in front of him stretching his legs, with the palms open. After untying the seven bundles one by one, he puts them upon the patient's palms after touching all his joints with them. Then he gets the nkio (flywhisk) and touches again with it the patient's joints while he says:

> 'Do not let it fold again, untie it, untie it completely, remove it at all'.

Finally,the mugao tells the patient to go and throw away the contents of the bundles in the bush, in a place where no one can find it. The mugao himself leads the patient into the bush and throws away the leaves of magombogombwe he used to prepare the bio.

4.17 Day XVI. The Case of Ndeke: Ritual of 'Mpingo'

Thursday, 15th January, 1987

The treatment of Ndeke continues after he has been left to rest at Kinyua's home during the whole previous day, once the ritual of kio had ended. Today my master will show me how to perform the ritual of mpingo. The work is left to Kinyua, whilst

M'Mburuki and Rukungi observe, sitting on one side.

BLESSING OF THE MEDICINE

The mugao Kinyua prepares kioria in the usual way: then he puts it in the half-broken pot and sitting in front of it starts blessing the medicine, keeping the horn for mpingo in his hand.

'I have called you kioria of mpingo, I swear by all the oaths,even if it is the oath of nthuthuuri (a very effective oath), or it is mpingo of kiswahili, or of Turkana, or of Igembe, or of the white man (he spits). Where are you from? I am from home (he spits). If it is mpingo of Kamba, and you young man (to the patient), you know how to talk, that woman is a real woman, I will tell her that this young man is a real man (he spits).
To be touched with this kiama (sorcery) of seven, the joints of the whole body, I swear by all the oaths, even if he was bewitched the joints of the body (he spits), or bewitched with the feet of the oldest women, or bewitched with urine (he spits), there is no kiama, I swear by all the oaths, it is pure water, it is the migration of ants and that of bees. To sleep good sleep like that slept by the hare in the seventh month, to sleep waking up, to walk with the toes (he spits).
To pacify the relatives and the clan and hold all the herbs (he spits). He comes up to be prepared gruel and in the eighth and ninth month herbs are stretched for him (he spits continously).
You were bush herbs, I swear by all the oaths, I have come to operate you from the bush together with the meat of the goat. I have called you kioria to help the body of a person (he spits). Even though it is kiama of penis by the sun, or it is kiama by the rising sun. If it is kiama of walking, of the moon, or kiama of growth of the night, or kiama or growth of the day time (he spits).
I swear by all the oaths, right now this penis of yours will start giving sparks facing the daughter of a person (he spits). He will agree with him as the oil is attached to the body, I swear by all the oaths. I have come to bless you (he spits), trotting a he-goat for you, trotting money for you, trotting bees (he spits). Bee is the animal of blessing, I swear by all the oaths. And you, as I stretch for joy my hands (he spits), I have not sent you to go and do evil (he spits), let us love each over, we just fight over grazing area, and I as Kinyua, may he hear me, even long ago he is

c my own posterity (he spits). Good muthega is good muthega, I swear by all the truths (he spits).
If you run after evil that is in the body, it will not still be there as nyambura (goodness) of that person. There is no kiama, I swear by all the oaths, it is wind, just wind that

is not seen anywhere, it does not show (he spits), may it not be known and may it not fall (he spits).
If he was bewitched with the kiama of bad luck, of contracted bulls which do not erect, I swear by all the oaths, there is no bad luck today, and even what is supporting you is bad luck (he spits). If he was bewitched with the kiama of those who are barren and told to perish without a child. I swear by all the truths, today we have come to fight for him (he spits). May he sleep good sleep. This penis to crack at one o'clock, at noon, let it crack today facing the thighs of a woman (he spits), just like that before a man was defiled by a woman, I swear by all the oaths. And you, there is now no kibitana in your body (he spits).'

At this point, the mugao bends down and pretends to walk like a cow. He simulates the animal while kicking onto the pot with the medicine he is blessing; he moves staggering and bellowing like a cow when heavy. Then he continues with the blessing of the medicine.

> 'There is no kiama. I curse the kiama of black muthega, I curse the kiama of Borana, I curse the kiama of number seven (he spits). There is no kiama, I swear by all the oaths. To remove the kiama, is to remove (he spits). I bless you with the left, the left (hand) has never beaten a thing, the left knows how to prevent stool (he spits).
> If it is muthega in the body, I swear by all the oaths (he spits), there is like beating something to pass, you leave your body in good health that moves, you finish and collect yourself with feet and hands like a monkey, a bush animal that has no mugiro (impurity), I swear by all the oaths (he spits). To be smooth like a nut or a lizard or a bird, to become flowers of the field (he spits). There is no kiama, I swear by all the oaths, It is to be faced by goodness like a beehive being faced by bees. To be protected by posterity like a banana is protected by the suckers, not to be distinguished in a variety of banana which is the original plant'.

THE RITUAL

Once the blessing is completed, Kinyua calls the patient to sit in front of him; then, dipping the flywhisk in the calabash containing the kioria mixed with water, he taps all the patient's joints with it while he makes several rounds around him

repeating the formula:

> 'There is no kiama, this water is a furrow of water that is opened all the time; it is opened and any water goes out (he spits) not to see a thing to be left, I swear by all the oaths, there is no kiama (he spits)'.

Afterwards, he draws nearer the patient asking him to show his hands: he briefly examines them and then starts pulling his fingers and toes until they produce a crack. Since some of them do not produce any sound, he asks Ndeke:

> 'Are these the fingers which were difficult (to pull)?'

Consequently, he applies some kioria on them while he says:

> 'Stretch hands for him, I want him called the father of Kanyua (he spits), the father of Njoka (he spits). Come, the father of Kinyua, come (he spits), well, well, it is fire, fire, fire'.

He pulls even the difficult fingers and toes producing a crack; then he demonstrates to the patient how to take a sip of kioria from the calabash without swallowing it but spitting out. Finally, he gives the calabash to the patient and while he drinks and spits he repeats many times:

> 'It is pure water, I swear by all the oaths, it is pure water.'

At this point Kinyua gets from his kiondo the uta and miqwi (the small bow and miniature arrows), then he unties the seven small arrows and starts shooting them using the small arrows against the patient's joints and neck while he says:

> 'You see, they are joints, joints. This is mpingo. This is but a neck. I come to remove you mpingo, I come to remove you mpingo (he spits), that was of a woman. I come to remove you mpingo of beehive (he spits).
> Even you Njeru (Son), as you come from the beginning (he spits), as you go to your relatives (he spits), go with all the migiro (impurities), I come to remove you mpingo'.

Next, Kinyua asks Rukungi to bring him the plate with

the pieces of meat his wife has prepared. He puts it at his feet after having cut the meat into several small pieces. Kinyua marks the plate with iraa and arranges some twigs and leafy branches in a circle around the plate itself. Then he takes the flywhisk and some horns and, holding them, he draws some semicircles over the plate. At this point, Kinyua asks the patient to kneel in front of him and offer him the pieces of meat using a sharp stick: he instructs Ndeke to take each bite using his teeth and then dropping it down on his side. He repeats the action seven times from different positions - in front, behind, under the arms, under the legs - while he recites the following spell:

> 'Do not swallow, spit it like this (he spits). Spit, spit things of mpingo, things of mpingo that was of the Owner of the Son, spit mpingo that was of a big man, spit mpingo that was of a short man. Spit it, do not swallow.
> (He spits) Kiama of mpingo, even if it is kiama of mpingo of tree fruits, or it is kiama of mpingo of the throat, I swear by all the oaths, today there is no mention of things of mpingo (he spits).
> I come to remove you mpingo, child. To sleep good sleep like that of a hare in the seventh month, you will sleep waking up and walking on your feet, to please relatives and clan (he spits).
> I come to remove you mpingo from the back (he spits). So you ate mpingo that was from the back, that is the one I am coming to remove (he spits). Quick. I remove mpingo this way and you go with mpingo, you go with muqiro (sunset). Never to be told things about mpingo, to remove is to remove, you remove all things of qendaqa (misfortune), you remove things of the Owner of the Son, you remove things of Njeru (sun), you remove things of Nyaga (moon).
> (He spits). There is nothing, it is sleep, it is peace, I swear by all the oaths (he spits), there is nothing.
> I curse the main kiama, I curse the blown kiama (he spits), there is no kiama. I come to remove you mpingo that was from a woman (he spits), so you ate mpingo because of nakedness, I come to remove you mpingo of the left, today no more of being told things about mpingo, it is sleep, you sleep, I swear by all the oaths, I remove you mpingo.
> (He spits). I curse the kiama of breaking the joints of the body , I swear by all the oaths. Even if it is kiama of breaking, today these are the biama that are coming to heal you (he spits), be united with them.You become health in the

body, there is nothing. Kiama, kiama, kiama (many times).
I come to remove you mpingo, I swear by all the oaths. There is nothing, even if you were cheated like that and you were bewitched crosswards (he spits), there is no mpingo, it is pure water, it is the migration of ants and bees, there is nothing, child. Come to pass this, you, I come to make you pass this way (he spits).
There is no kiama, it is just wind, the wind shakes trees, it is not known where it is moving to. And this evil, there is none, it is to go out through the way (he spits). I come to remove you mpingo.
There is no kiama. Wake up! Wake up to do your work, to walk on your toes, to feed the relatives and the clan, to fight for all that is good. Let love each other like oil and its container (he spits). That is what I want, I swear by all the truths.

The mugao ends the ritual of mpingo by cleansing the patient's tongue with kioria. Then the patient is made to sit and Rukungi makes seven small superficial cuts using a razor blade in different parts of his body; then, he applies some kioria inside them after spitting and rubbing on every cut the same ointment. The remaining kioria is put in a horn and given to the patient to drink.

4.18 Day XVII. The Case of Ndeke: Ritual of 'Mugiro'

Friday, 16th January, 1987

The treatment of Ndeke is coming to an end. After trying with three diffferent rituals related to the uroqi - ruriqi, kio and mpingo - M'Mburuki tells me that they have decided to conclude the treatment with the ritual of mugiro, since the divination discovered it - the rukuu of the death person - and they are not sure that the rituals performed up to now could be enough.

PREPARATION AND BLESSING OF MEDICINE

The three agao come back from the bush where they have gone to collect the four plants they use to prepare the medicine for mugiro they call ng'ondu: mukinduri, mubuu, mukenya and mwegere. They are all tubers whose roots are used by them to prepare the ointment for the patient. It is put in a calabash adding some water, while some leaves of magombogombwe are dipped into the mixture which is to be whisked onto the patient by Rukungi. The latter is now blessing the herbs using some intruments he first shows me: some horns, the flywhisk, the horn for mpingo (used also for mugiro, since it carries all the biama - he says) and the gourd containing the muthega for mpingo. Holding all these things in his hands, the mugao sits down in front of the calabash containing the ng'ondu reciting the following spell:

> 'You were bush herbs, I have called you mugiro (he spits). To become the muthega of mugiro (he spits). To be touched with them even if you were defiled by your mother or rukuu was in the home and it happened you were 'closed out' as a child (he spits). To be touched with these leaves, you become full as a kairangi (type of rat), as this penis erects, the body produces fathers and mothers (he spits).
> You were bush herbs, I have called you, all of you, being four, to be touched with these herbs you are cleansed mugiro. Even if it is a person who defiled you, and you happened to be disabled to fail to become what other people become (he spits).
> To be touched with these leaves, you are mugiro, are you anything else ? (he spits). I have called you kioria but you are kioria to treat all things; that is, even if it is rukuu you were defiled by your dead mother or the child of the home being the one who brought you this mugiro, or your father outside the home and you, being a child, it happened that you were 'closed out' (he spits). May this mugiro migrate, migrate like the migration of ants (he spits). I have called you mugiro.
> All things have to be fulfilled as we love each other with you, like castor oil as the precipitate separates (he spits). I want all good things, to be touched with this mugiro, it is to be uprooted completely, to come out, to be seen by people they say, 'I swear'.

I will go, that mugiro which kept him in the house, or that prevented him to recover in the body will go. Mugiro made him suffer, or it is rurigi that made him suffer. But to be touched with these leaves, it is to be cleansed of mugiro, you come out and people see it is mugiro that was making him suffer, or it happens to be mpingo, or it was any kiama, even if it is of Kamba or of Taita people'.

THE RITUAL

The patient is made to sit down with his legs stretched out and his hands lying relaxed on his thighs. Kinyua places the horn for mpingo at his feet and puts the rings made of tuber roots (nkooro) on each of the patient's toes. Then he gets a bundle of leaves of magombogombwe and starts treating the patient after dipping them in the calabash with ng'ondu.

'Today I have come to point to you where it went (the sun) with evil, it is the one that defiled. Your thighs are in love with those of your wife and the wife's are in love with yours. You agree for eight months and the ninth month hands are spread for you and the woman has the thighs filled and fills the hands (he spits). A pot is cooked for you (he spits).
Come, I cleanse you mugiro, I cleanse you mugiro that came. Come, I point out mugiro, I cleanse you mugiro, I cleanse you mugiro of the owner of the sun (many times)'.

At this point the mugao brings the bundle of leaves very close to the patient's mouth, making him touch them with his tongue and then spitting in the opposite direction from where he came from. He repeats the action from all four directions.

'I come to remove from you mugiro, I come to point things to you (he spits), I come to carry mugiro away for you this way.'

The mugao makes a pause and moves the bundle of leaves as though he was throwing something away, shaking the leaves to make sure that whatever he was sweeping away has dropped off.

'Mugiro! Those evils fly off and leave our person in good health. Go, mugiro, the child got it in the evening. Mugiro,

the evil that was brought in the morning came at noon, came at three o'clock, came in the evening.
I go and find mugiro, that was of a brown person, mugiro that was of a child, that was of the pregnancy, that was about to be delivered (he spits). I come to remove from you mugiro this way (many times). To remove mugiro of the daytime and of the silent birds. To remove mugiro of the night that was of the woman, to remove mugiro of the night that was of the man, that was of twins, that was of two umbilical cords, that was of the man who was childless'.

The patient is asked to lift his legs off the ground by bending the knees to leave a space between his legs and the ground so that the mugao can pass the bundle of leaves through the gap and up towards the patient's mouth.

> 'I come to remove from you this mugiro,I come to remove from you mugiro that was of the left hand, of the woman, a woman is disposed of her left hand. But today I must remove, fill, fill on the laps, fill the eight months and on the ninth to have hands spread by woman (he spits), to be cooked gourds until they are ready (he spits).
> To come to point to you the hand of well being (he spits), I come to face you with the hand of well being so that you will be faced by goodness, since you will sleep well.
> This penis that sparks, to spark towards the thighs of a woman, as the thighs of a man never miss those of a woman at night (he spits), and you should not miss good things (he spits). He comes out with a goat quickly, and we make good things.
> Let me come to remove from you mugiro, to remove that was of the right, of the father. It is to be smooth like ntinda (a type of lizard), the way it stays in the soil without being touched by the soil. To clean is to clean mugiro, to clean mugiro of the only child, to clean mugiro of the only son, to clean mugiro of the only elder, to clean mugiro of the relatives, to clean mugiro of the clan, quickly we remove mugiro'.

At this point Kinyua calls Rukungi to assist him in the treatment. They hold together the bundle of leaves, making the same movements as before while reciting the spell in unison. Meanwhile, my master explains me that it is a ritual practice for mugiro to be treated by two agao at the same time.

'We come to remove mugiro, child, of relatives and clan,

child, that was of a person who died in the field, that was of twins, remove mugiro child, let us remove mugiro.
Let us cleanse things of kibitana, to cleanse is to cleanse. We are sweepers, we have come to sweep, we have come to deny ourselves mugiro, no more to be told things about mugiro today. Be happy relatives and clan, produce girls and boys.
Let us come to cleanse you of mugiro that was of the back, we remove mugiro.We come to remove mugiro, child,that was of relatives and clan , that was of cleansing rukuu. We come to make you happy, to prepare food for relatives and clan. Prepare food for all girls and boys'.

After treating the patient standing in front of him and from the back, the two agao kneel down and start treating him from that position.

> 'Let us come to cleanse you mugiro that was of a person who was kneeling down or who was coming when your mother was kneeling down giving birth to you . Let us come to cleanse you of mugiro of relatives and clan. To wash, we have washed mugiro, to remove, we have removed mugiro. Child, we have removed mugiro, make her happy.
> Njeru, as you go home go with these words endlessly in the sky. Remove, remove migiro, let it jump that way.
> We come to remove from the back, child, so you ate migiro from the back, you ate something to arm you with the back.
> Today, that is the thing we are coming to remove from you.
> To cleanse is to cleanse, to walk on your toes, you please relatives and the clan. Let us remove from you migiro, those things you ate and you were defiled, these are the things we come to reject. Sleep the sleep that is slept by the hare in the seventh month'.

Afterwards, the two agao move from the tamarind tree onto the pathway, where they dig a small trench, pour some kioria from the calabash into it and then, dipping some of the leaves into it, they start treating the patient on the pathway, where he is sitting. The action is in four stages, one for each direction.

> 'Let us come to remove mugiro which was of relatives and the clan, which was of the only son, which was of the road, which was of pregnancy. Child, so whom? Today, we will cleanse, let us come to cleanse you of mugiro.As you go home (to the sun), go with migiro'.

> 'Let us come to remove from you mugiro that was from the back, that was of the people who are bending. We come to remove from you this mugiro (many times).'

'Yes,we come to remove from you mugiro that was of the foetus, child. We come to remove this mugiro from you (many times)'.

'We come to remove from you mugiro that was of stretching hands,that was of relatives and clan, child.Never to be told things of mugiro again, to sleep is to sleep like the hare in the seventh month. Those who will come through here (pathway), let them carry this migiro'.

The treatment is coming to an end: the two agao pour more kioria into the trench whilst the leaves are removed and thrown away. Then they ask Ndeke to take some kioria and wash his legs and arms with it, touching only the joints. He carries out this operation while standing over the trench and the bundle of leaves. Finally, Kinyua tells him to stretch his hands out to allow him to wash them with kioria while standing in the same way; Rukungi does the same operation on his legs reciting the following spell:

'There is nothing, I have come to cleanse you of mugiro (he spits). There is no mugiro to affect you again, even if it is of relatives or it is of a bride, or even your mother had a bad effect. There is nothing (many times)'.

The bunch of leaves on which they were standing is untied by M'Mburuki (being the one who tied it, Kinyua explains to me); then the leaves of magombogombwe are left on the pathway, so that the passers-by will carry away the migiro, the three agao tell me.

We return to the tamarind tree, where M'Mburuki gets out of his kiondo a special medicine, he says, called muthega gwa muukio (medicine for erecting) to give to someone who was bewitched by buruncha or uthigani (love sorceries).He shows me the contents of the medicine, explaining that it is a mixture of the herb called mukunda; then he gives it to Ndeke to drink at home. The

treatment is finished: we can return home.

4.19 Epilogue. The 'Old Ugao'

Monday, 25th January, 1987

The road climbs over the rocky hill called 'nyomba ya mbiti' ('house of hyenas'), a very arid area famous for its poisonous snakes, and goes down towards the dry seasonal river called Muthangachu. I am going with my master and his two assistants to Ngunku's home,where my initiatory itinerary will end. M'Mburuki had promised to show me one of the practices of the 'old Ugao': the ancient preparation of the muthega using an instrument the Tharaka inherited from their forerunners, the Gumba people. He did not tell me what kind of instrument that was and I am very curious to discover it: his friend the old mugao Ngunku, he said, is the last one who possesses such an instrument and knows how to work with it.

When we reach the homestead, we find a small and thin figure with a white beard who, in spite of his evident old age (more than eighty years old, M'Mburuki told me), is hopping here and there with great agility. He looks happy and excited because of our visit: he calls us to sit in front of his hut where we talk about this and that while drinking the nchobi (traditional sugar cane beer) he has offered us.

Afterwards, he goes near the fence and brings the rugio (half-broken pot) containing all the herbs he has prepared for us: he digs a small depression in the ground and places the

rugio into it. Then he goes into the hut and brings out the instrument: it is a blowing apparatus he uses for blowing air into the fire to burn the medicine. About two metres long, it is composed of two leather pipes joined to a central wooden part called kimunguru, ending with a clay part named nkerua which is put near the pot to produce the fire. After setting the bellows on the ground in the proximity of the pot, he draws some other items out of his hut: a bundle of sticks he calls gikamati, some horns, the particular string called rurigi, some pegs and shells, and a statuette representing an angel. This latter is evidently a sacred item which he was given, he says, by a priest in Mombasa, where he was taught the 'Ugao of the Coast'. He places most of the objects in between the two leather pipes; whilst he hammers the pegs into the ground to form a semi-circle all around the bellows, setting the rurigi on them and putting a shell at the foot of each peg. Finally, he takes the nkio (flywhisk), goes near to the pot with the herbs and standing there he blesses them saying:

> 'Heaven and hearth (he spits): it is the same (he spits). It is to keep the illness in the body (he spits). This muthega, if someone with a illness is given, it will leave him and his body will stop to ache (he spits). Njeru, bring goodness; Nyaga, bring goodness (he spits)'.

Next, sitting in front of the blowing apparatus he starts using the bellows alternatively. Nothing happens. He takes some antelope horns from his kiondo (basket) and stands again near the pot reciting this spell:

> 'It is to blow the snake that fills the sky (he spits); an elephant fells the trees (he spits). there is no other kiama (sorcery), there is only a kiama for the night and the day, a kiama of nthaama (he spits), a kiama of the river.
> Good kioria, which is given to someone in Kithuma (a place)

and he wakes up, it all moves with air and leaves without making someone cold. The sickness inside would move out, it is empty water (he spits), it is all cold (he spits), it is dew (he spits). You become smooth like a lizard, it is nothing (he spits).
Kiama that was of a spear joining those of Chiangio, it was of the great Urogi (he spits), that was for Nkunje (a very old age-set), that of waking up, and it is waking up, kioria!'.

He returns to sit down in front of the bellows, using the pipes alternatively. After a short time, the herbs in the pot start producing a light smoke column: they are burning. He continues with the alternate movement to increase the fire: after few minutes, the herbs are completely burning. At this point, he picks up the statuette of the angel and uses it to bless the muthega in a smoke cloud saying:

'Let us pray the angels for you good muthega that wakes up someone at the middle of God, you wake up people of all the biama, those which come at night (he spits), those which were for the day, you move them away and away (he spits), like monkeys destroying farms (he spits).
It rained at night and rained, then there was dew, then there was sunshine and the dew disappeared; and the muthega in the body will also disappear like that. There is no urogi which leaves in the body, either of kibitana, mpingo, gichonono or anything else. It is nothing but pure water'.

Ngunku returns to the bellows to increase the fire again, then he continues the blessing saying:

'There is no muthega for urogi: black urogi of red diatomite (he spits). The muthega for the sun, the muthega for the moon, if you take this muthega you recover straight off. There is not even headache, no body pain, it is pure water (he spits). Even if he has been bewitched where someone is stepping at the middle of the river.
I refuse the black urogi, that of kibumba mwezi, to mistake is to mistake, the muthega would wake up and wake up, to remove is to remove all that muthega in the air.
If you take this muthega, the muthega in the body will disappear (he spits), it will come out. It is air, it is an elephant felling trees, an elephant crossing a river, it is not mugiro and you will not get mugiro (he spits).
All this kiama, kiama of the day and kiama of the night, kiama of time (he spits). Kiama of mpingo that had urogi of buruncha: it is that of Mwimbi, that of Kamba, it was the

first one for Tigania, Gikuyu and Igembe'.

When he is finishing the blessing, the fire is about to go out, since all the herbs are almost completely burnt. Then he takes a gum pipe called murangi and drops some water through it onto the dying fire. Questioned about the meaning of this, Ngunku replies:

> 'I have used the murangi because the water is moving out through the holes in the pipe the way muthega would move out of the body. The pipe has some holes so the muthega would move out of the body the way it moves out of the pipe.'

Finally, he ends the ritual by taking out a small bell from his kiondo and, ringing it continuously, he says:

> 'I am cleaning up and cleaning up. It would get cold, it would make the body cool (he spits continously), because of kibitana , because of black uroqi that was from Tanzania, from Nyamwezi , from Giriama and from the Atinku.
> I refuse the muthega of the sun and of the moon, there is no kiama of the night and of the day. There is no rukungo for muthega, there is only one rukungo.
> Njeru, take goodnees, Nyaga take goodness and you go home with it'.

FOOTNOTES TO CHAPTER 4

1) In the text, the name of the plants are in kitharaka since the most part of them have no common Kenyan-english term; the botanical identification of part of them with their Latin name is to be found in Appendix E.

CH.5 'KURINGIA': DIVINING THE FLOW OF EVENTS

5.1 The Structural Elements of 'Uringia'

The ethnographic materials regarding my personal initiation as a mugao permit, I believe, different levels of analysis. For example, one could question to what extent my initiation was 'typical' compared to that of other Tharaka apprentices; or one could be interested in analyzing the strong emotional component of the pattern of relationship between the master and the apprentice; alternatively, one could analyze the process by which Tharaka agao created medical knowledge. In this context, I am convinced that the most relevant entry-point is to try and analyze the elements I collected in order to understand fully the Ugao jurisdiction and see whether it is possible to trace the linkages with the 'cognitive structure of illness' which I singled out in order to better explain people's health-seeking behaviour.

As we have seen in Chapter Three, the role of traditional medical expertise in 'problem definition' becomes fundamental when people think there is a hidden dimension of causality implied (1) which requires a divining session to be discovered. We have also seen as the cognitive product of this 'second-order categorization' is a label, a cover term whose contents are almost completely ignored by the lay patient. The problem I now want to tackle is therefore to explain how Tharaka medical expertise works in defining the sick person's problem; this will

allow us to understand the nature of the labels used. To achieve this purpose, I shall first briefly examine the different anthropological approaches to the study of divination, particularly in the African context, in order to define the one most appropriate to analyze my ethnographic material.

The remark I want to begin with is, in John Mbiti's words, that 'with few exceptions, African systems of divination have not been carefully studied, though diviners and divination are found in almost every community' (1969:177): this is probably due to the attitude of most anthropologists towards divination and to the marginal status they give it as a consequence of such an attitude (2). Evans-Pritchard's fundamental work on Azande (1937) undoubtely contains the first serious study of divination. In his description of Zande's poison oracle, he stresses the self-interested utilitarian use which this Southern Sudan people makes of it in order to counteract witchcraft. This brings him to draw a clear-cut distinction, in Zande thought, between the two separate realms of the 'mystical' and the 'objective', probably taking the Western dichotomization of religion and science as a mood (3). But this is precisely where Evans-Pritchard's stance fails, according to Peek, 'because divination makes definite use of both modes of thinking' (1991:8).

The British social anthropologists'tradition developed the functionalist approach initiated by Evans-Pritchard, even though little attention was devoted to divination in spite of a much greater body of scholarship accumulated on witchcraft and its relationship to the social system (4). With witchcraft considered

as a 'social strain gauge' (Marwick,1970) and witchcraft accusations seen as a means of adjusting social relationships and allocating responsibility (Gluckman,1972), divination played only a marginal role, as a derivative of the social system to be primarily understood in terms of other social institutions such as kinship and politics.

Comtemporary scholarship on divination has been categorized into three main approaches by Devisch (1985), who terms them as 'structural-functionalist', 'external, cognitive' and 'internal, semiotic and semantic' (5). It is the last approach which seems particularly useful in African societies, where divination plays a central role in the medical, social, legal and political systems. The peculiarity of divination as a system of 'knowledge in action' (6) in the African context involves 'a combination of (as we commonly label cognitive processes) "logical-analytical" and "intuitive-synthetical" modes of thinking, while in the European tradition the separation of these modes is rigidly mantained' (Peek,1991:3). Therefore, to study African divination we need to understand the body of knowledge on which it is based; whose value lies, for many African peoples, in its hidden, secret nature, available only to certain professionals who, thanks to their training and skills, are capable of dealing with and using it at will. In this approach (which is the one I shall try to follow), divination becomes the central revealing moment of this esoteric knowledge, the gate to gain access to the world of invisible forces.

The description of the divination session relating to the

case of Ndeke in my own apprenticeship as a mugao should provide appropriate material for a deeper understanding of this part of the cultural machinery which the Ugao jurisdiction implies. Uringia (divination) in this case is carried out directly by the mugao Kinyua, who is one of those agao who know and practise it. His divination style, though it contains a certain degree of individual idiosyncrasy, shares some fundamental commonalities with the other divining sessions I had the opportunity to observe - one by the mugao M'Meeni, one by the mugao M'Kariigua, one by the muringia Gauki and three by the muringia Mukwaiti - so to allow me to try and single out what appears as a series of structural cultural elements in the Tharaka divination process. I shall specify any individual particularity every time it appears significant.

The first structural element in Tharaka divination is the divining apparatus: the range of possibilities here is clearly limited. Kinyua uses a glass pipe with some liquid inside and two floating objects in it (plus some snuff); Mukwaiti uses simply snuff which she drops from a gourd and puts on her palm; Gauki uses a small bottle similar to Kinyua's glass pipe; M'Meeni uses a calabash with water mixed with tobacco inside, dropping it on the ground and observing its dispersal;M'Kariigua uses a small gourd with seeds and some sticks inside, which he shakes and then draws out and arranges in order, on a goat skin, to count. Some agao also told me they uses a mirror which they carefully gaze into. Is there any possible commonality in this range of different divining instruments? Beyond the apparent diversity of

these apparatus it may be possible to trace a common metaphoric meaning: that of the container and of the contents. Many discussions with aringia and agao, and particularly the teaching of my masters during my apprenticeship as a mugao, support this interpretation. The container - whether a gourd, a bottle, a pipe, a calabash or a mirror - stands for the world where human beings live. The contents - being snuff, water with objects or snuff, or images - refers to the reality of the events in the world itself. The first - the world - is one and fixed; the second - the events - are many and continuously change. Drawing out some of the substance contained in the container (or observing its particular disposition at a certain time) relates to the action of selecting a specific configuration among all the possible realities of events in the world: the particular one that matters to the client's case. The muringia's specific ability consists exactly in singling out the proper piece of reality to understand his/her client's case. This explains the reason why he prefers to repeat the action of drawing out the substance from the mbugu (or re-observing its configuration in it) when he/she is not convinced of having got the exact images of events he expects.

But how can the muringia produce this process of reality selection? This leads us to the second structural element in Tharaka Uringia: the sensory mode utilized. To catch the flow of human events which are the most meaningful for the client's case requires a special sensory ability, a uncommon power of detection only some particular people can have. In Tharaka this is not obtained, as in many African cultures, through spirit

possession or other altered states of consciouness (7). The muringia remains in a relatively normal state of consciouness, in which the primary sense utilized is the vision. The Tharaka utilize the verb kwona, to see, in order to describe the heightened ability of the muringia: he is somebody who can see what is the problem when common people cannot see. The relationship with the mbugu, the divining apparatus, is a fundamental support of this power: Kinyua continously dialogues with his mbugu, questioning it and asking 'light, that light that clears darkness'. This special visual acuity, which can be read as a metaphor of a particular intuitive power, cannot be taught: that is why it can only be received by a mystic vision or an instructive dream by the muringia. There is no apprenticeship or family inheritance for the art of Uringia. This can also be a cue to understand the reason why the aringia are women whereas the agao are men: the mugao Kigwato once told me that women 'can better understand certain things, have a better knowledge of them', implying their skill at understanding better the typical interpersonal conflicts that produce illness. Nevertheless, even many agao practise divination, which shows that the particular sensory power it implies cannot be rigidly attributed by gender. What is probably a real gender matter is the fact that when this power manifests itself in a woman, she is in no way allowed to enter the mugao profession, which remains a totally male reserve.

The third structural element is the location of Uringia in time and space. Regarding the latter, Kinyua uses the shade of a

tamarind tree to practise his art; Mukuwaiti a rock not far away from her homestead; the others generally prefer sitting on a mat inside their own homestead. In any case, what seems common is the choice of a particular spot, different from the usual sites of everyday life or separated from them by means of a particular object (the mat). The aim is to create an appropriate space, a special environment - i.e. 'sacred', 'set apart' - where the event of divination can take place without any interference by external agents.

Even the time of divination has its own peculiarity: it appears restricted to certain hours of the day. Kinyua refuses to divine at noon: he invites the people present to wait until the 'time of divination' (6 p.m.). The mugao M'Kariigua told me that the proper time for divination was the morning. The apparent contradiction of these two versions disappears if we look at what they have in common. Morning and afternoon are in fact both intermediate periods between the two opposite poles of midday and midnight (intended as 'full day' and 'full night'). And this quality of 'intermediate period' seems to be the common element the two agao share regarding the proper time for divination beyond their apparent disagreement. On my request for further explanations Kinyua, looking up, talked about 'the proper condition of the forces (spirits) in the sky' during such period.

Other African people share these time restrictions in divination: the Azande never divine in the heat of the day (Evans-Pritchard, 1968:281), while in Madagascar divination sessions never occur at night (Sussman and Sussman, 1977:282); finally, the Dagaaba only divine in the early morning (Kuukure,

1985:106). Peek suggests that this particular location of the divination event in time (and space) serves to establish and maintain its character of liminality (1991:197): since it permits transworld communication, divination becomes a portal between different realms. This interpretation seems to me consistent with Tharaka culture: if the day is the time for everyday profane activity, the night is the time of the sacred world, the world of the nkoma (spirits). Therefore, at the apex of the day, at noon, the spirits are silent; in the middle of the night, the spirits are too dangerous, it is impossible to keep them under control (unless for bad magic, urogi, which is in fact performed at night). Thus the proper time for divination, in this symbolically related double opposition between day and night, profane time and sacred time, are the intermediate periods between the two poles: namely, morning and afternoon, between sunrise and sunset. The character of liminality of these intermediate periods matters for the success of the act itself. But this character attributes to divination the quality of a rite de passage (Van Gennep, 1909), whose representation of time is exactly the same as we have above illustrated (Leach, 1961). If we are right, it becomes necessary, in order to support our argument, to determine in the divinatory event the three stages which represent the constitutive parts of every rite de passage:if such a three-stage structure really exists in the divination, we shall have probably gained a better understanding of the very nature of divination itself.

The fourth structural element of uringia is a key towards

the solution of the problem. If we look at the divination act as a communication event, we can consider it as implying a verbal code. In fact, apart from the utilization of the divinatory instruments we have already explained, most of the behaviour that takes place in this communicative event is verbal behaviour. That is to say, a divinatory session is fundamentally a 'speech event' whose nature we should now try to understand. What strikes us immediately in this speech event, is the initial amassing of jumbled ideas that appear to be inconsistent: Kinyua speaks of a home in a certain place with iron sheets, of two people, of a sudden death followed by a second death after some months, of a journey in the forest, of an evil person. Subjects, events, spots and objects are 'extracted' from the mbugu in a chaotic way and offered to the client's scrutiny. The dialogue that follows plays a fundamental role in selecting and determining among a random pool of ideas and metaphors those that are most appropriate for the client's problem.

The case of Ndeke I reported looks particularly interesting because it shows a certain degree of 'resistance' by himself: the results of Kinyua's divination are denied twice before the two can reach a certain degree of agreement on some significant elements. Their dialogue is crucial as the revealed information is discussed and debated in order to produce an agreed version of the divination findings. The relevant elements are separated from the non-relevant ones in this cognitive process; and a series of causal links are established among the former. At the end we have an ordered series of events that produces a classification

of the client's problem: it is urogi due to two kinds of sorcery, rurigi and mpingo. What David Parkin terms a 'process of semantic disentanglement and clarification' (1991:183) is therefore essential in determining an ordered reassembly of the initial chaotic material into a proper diagnosis.

How can the muringia produce this transformation of the divination speech? At the beginning, it is almost exclusively a diviner's speech, while the client's role is often reduced to an affirmative or a denial function. The muringia is the source, the transmitter of the message; whereas the client is the receiver. But the receiver response plays an important function in their dialogue. It produces feedback, that is a series of data available to the source in order to allow him/her to make qualitative judgment about the effectiveness of the communication situation. The muringia takes the client's responses into great account, in order to adjust and to adapt his/her message to the ongoing situation. The theory of communication teaches us that feedback and response are not the same thing, even though they are clearly related:

> 'Response is what the receiver decides to do about the message while feedback is information about communication effectiveness. The two concepts are related because response or a lack of response is the normal source of feedback' (Samovar, Porter and Jain, 1981:16).

I can argue that this is exactly the mechanism that works in the dialogue between the muringia and his/her client: the outward display by the client of emotions, feeling or thoughts either by words or gestures (or other kinesic or paralinguistic codes) is carefully observed and 'read' by the muringia in order

to use this information to little by little sharpen and refine his/her message. The case of the divination session of Ndeke is clear: at the beginning he looks highly sceptical and scarcely cooperative towards what he had been told by Kinyua (8). Kinyua himself looks quite annoyed and worried, but he controls his reactions using his mbugu, relieving his disappointment by questioning it repeatedly. After three times the divination achieves success: it seems that he has focused on some elements - a certain person who had died, Ndeke's father and his two cases of land dispute - that have shaken the previous impassiveness of Ndeke. Ndeke looks much less steady than before: he starts changing his negative attitude into a more cooperative one and, at the end, he looks quite astonished at what he has been told.

5.2 Tharaka Etiology of Illness

But what is the real nature of the message he has received? This introduces us to the fifth structural element of divination event: the kind of knowledge produced. Once the dialogue between the muringia and the client has produced a selection and a re-ordering of the initial cluster of jumbled images, the following stage attributes the proper causal connections to the events selected in order to assign them a meaning. This making-sense out of a muddle of simultaneity and synchronicity necessarily implies an order whose nature is essentially symbolical. The task of the muringia here is to select among a range of possible interpretations of cause and effect the one that matters in order to explain the client's

problem. That is, a diagnosis. In doing so, the muringia reveals the hidden level of causality, the reason 'why'. The symbolic nature of this 'way of knowing' (Peek,1991) is given, as Devisch suggests, by its structural causality, rather than a linear one; it cannot be adequately grasped by conventional categorical thought (Devisch, 1991).

If we carefully examine the divinatory etiology used by the muringia, we can see this symbolic logic at work. He/she in fact utilizes a relatively homogeneous etiological grid in which to situate the afflicted world brought up by the client. This grid includes a range of five possible interpretations, which the Tharaka label as kibitana, mugiro, gendaga, kirumi, and urogi. The actual meaning of each of these terms is explained in details by my masters during the apprenticeship I described in the previous chapter. Here I shall try to summarize the common logic behind them.

Kibitana relates to the sphere of the sexual behaviour of the individual and of its social consequences. It is an impurity that affects him/her when engaged in illicit sex, particularly in an extra-conjugal relationship or during the wife's menstrual period. It is believed to cause sexual impotence and sterility, provoking also abortion.

Mugiro relates to the sphere of the relationship with ~~the~~ death: it is a kind of impurity (rukuu) that arises from physical contact with a dead person or his/her personal belongings. It also produces sterility and impotence.

Gendaga relates to the sphere of accidental, extraordinary

natural events like twins, physical deformities, or any misfortune. It can produce a series of sicknesses or misfortunes following on one another in rapid succession.

Kirumi relates to the sphere of the relationship between young and old people, when the former offends or disobeys the latter. It becomes effective after the person who uttered the curse has died. It can provoke madness.

Uroqi, finally, relates to the sphere of social relationships in general, particularly to such problems as envy, jealousy, or malevolence. It is the most complex etiology, which includes at least seven sub-types, each one implying a different kind of sorcery technique:

- mpingo is a kind of sorcery mainly used to prevent the stealing of property or to catch the thieves;

- rurigi is special string used to 'close' the path where somebody is supposed to pass in order to affect him/her;

- kio is a type of sorcery made by 'tying' different parts of the affected person's body;

- mero is a very lethal poison used to kill somebody by ingestion;

- nkaru is another very effective poison, but affects sexual organs by causing swelling;

- mubarukio is a kind of sorcery that provokes serious madness in the affected person, making him/her go around naked and scratching himself/herself;

- uthuki implies magical objects inserted into the afflicted person's body.

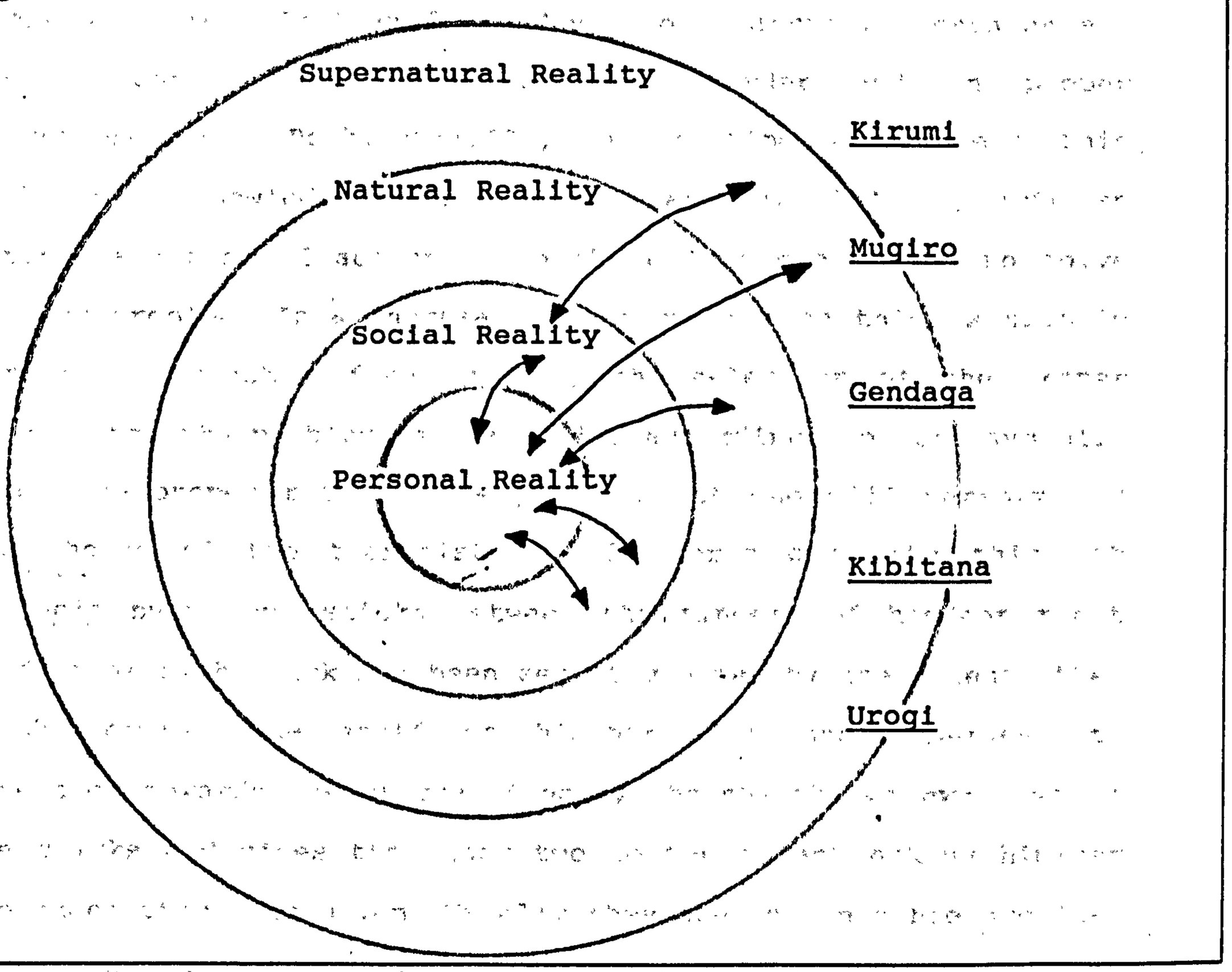
In relating his/her client's problem to the above

etiological grid, the muringia is not concerned to determine how the illness was caused (the immediate causation); he/she is instead concerned to find out the reason why the illness was brought (the ultimate causation), the origin and the meaning of what has been happening (Evans-Pritchard, 1937). So far, my analysis offers nothing new. But what is interesting is the way by which the muringia arrives at her solution. In fact, the type of etiology used does not determine the temporal axis of a causal chain or any sequence in a linear chain: this would represent the common, popular way of thinking and knowing. The way of knowing utilized by the muringia is of a very different nature: being much more interested in relating the various dimensions of the human existence, it determines a network of structural causality. It is on the basis of such semantic connections that the source of distress is determined and a symbolic meaning is attached to it.

In fig. 5.1 I try to sketch a map of the way these symbolic ways of knowledge work in Tharaka. The different dimensions of reality are linked together in a network of structural causality by means of the Tharaka emic etiology (9). In this multidimensional structural model of causality the sickness is always the result of the interrelationship between two or more dimensions of reality affected by some form of disequilibrium. Particularly, kibitana and urogi register an imbalance in the relationship between the individual and his/her social context, either in the sphere of sexual or social relationship. Gendaga defines a disequilibrium between the

individual and the nature, either in terms of superabundance or limitation of the latter. Mugiro, through the rukuu (death impurity), connects the individual with the supernatural realm.

Fig.5.1 THARAKA EMIC ETIOLOGY: A MULTIDIMENSIONAL STRUCTURAL CAUSALITY



Finally, Kirumi bridges together the three dimensions of the individual, the social and the supernatural because of the relationship it establishes between the young cursed person, the elder who curses and the spirits of the ancestors (nkoma cia bajojo).

The muringia, using this symbolic grid, offers a socially recognized, meaningful explanation of the client's problem; enabling him/her to impose on it analogically a problem of a similar nature which has been treated in the past. This leads us to the last structural element of the Tharaka uringia: decision-making. If 'the final divinatory narrative contains all the elements, now placed in proper order and in proper correspondence' (Peek,1991:203), it is time to convert this symbolic knowledge into practical action. That is, into an appropriate plan of action which the client can follow to solve his/her problem. In a Tharaka divinatory session this is usually performed through a final ritual, the selection of the proper mugao. Once the problem is classified according to the symbolic grid, the proper ritual is suggested: but who will perform it? The choice of the therapist usually works out like this: the muringia puts four sticks between the fingers of his/her right hand after each stick has been secretly named by the client; then he/she drops some snuff on his/her palm and observes its direction towards the sticks. Finally, he/she throws away two of the sticks and gives the other two to the client asking him/her the names they were given. Usually they are put in a hierarchical order: one is the first selected, the second one is a reserve if the first fails or is not present.

The apparent objectivity of this method guarantees the client the choice of the right therapist to ensure proper treatment for the specific problem: this decision-making process is the apparently contradictory practical result of the previous

ritual production, selection and ordering of symbolic meanings. Peek is convinced that 'it is exactly at this point that earlier analyses of divination floundered' (1991:203): he suggests that it is the 'crucial dialogue' between diviner and client that plays a substantial role of mediation between the symbolic world and the practical reality. I can argue that this is only partially true, at least among the Tharaka, since the function of the dialogue is mainly, as we have seen, to select and order the initial superabundance of meanings. It is my opinion - supported by my field oservation of divinatory sessions - that the client's final plan of action and the decision-making it implies are the result of a kind of negotiation process between the muringia and his/her client as to what to do, and this the rite of the sticks I have described ritualizes very well. The muringia is not allowed totally to direct the client towards this or that mugao; the latter maintains an autonomous power to select the range of possible therapists (he/she names the sticks); but he/she needs help in order to make the proper choice which only the particular power of the muringia can provide.

5.3 Divination as a Rite of Passage

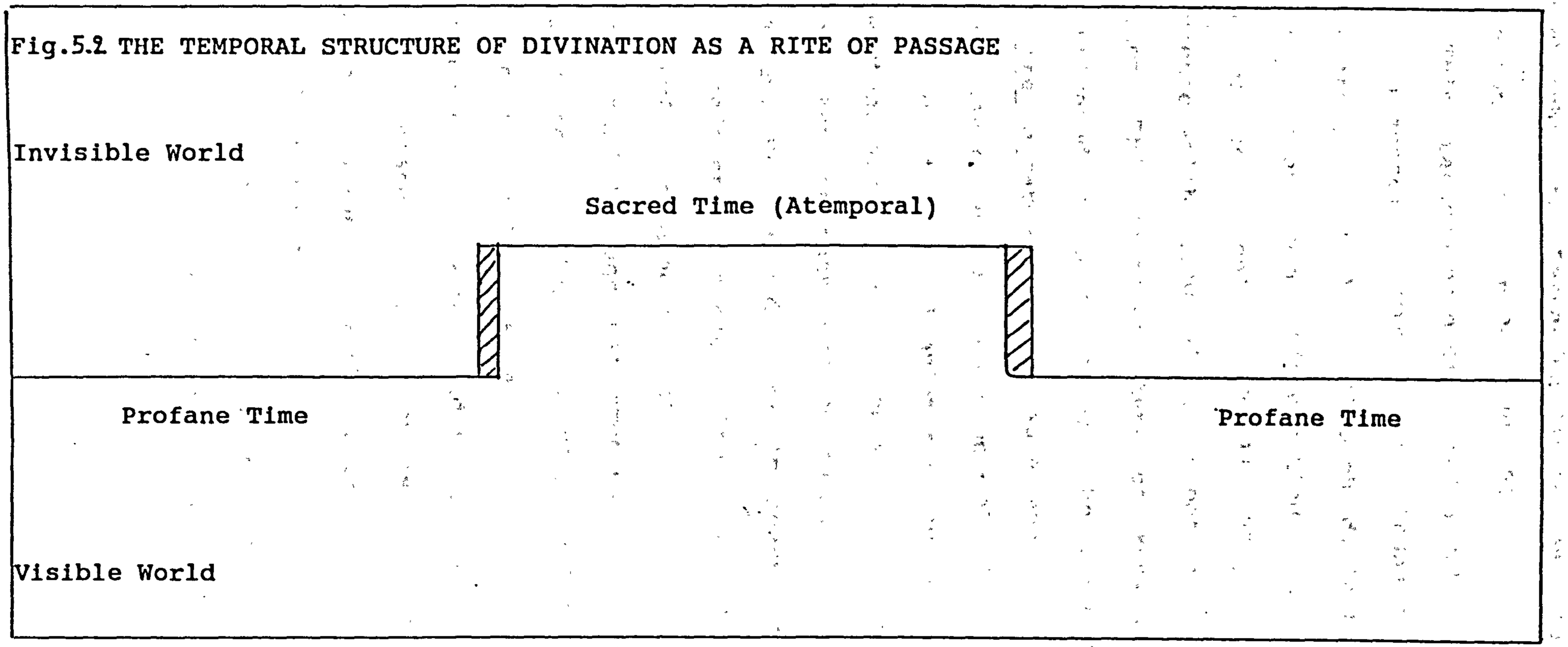
In concluding my analysis of Tharaka divination, I must return to my previous suggestion concerning the liminality of divination and develop it. As I said, the liminal character of divination due to its intermediate temporal location suggests we should categorize it as a rite de passage: if

so, I should now be able to discover the typical three-stage structure of this kind of ritual. The six structural elements I have analysed one by one in detail, if looked at all together, can outline just such a figure.

Using the general three-stage temporal model proposed by Leach (1976), I shall locate each element in the structure (fig.2). The subject of the process is the diviner's client, a person with an existential problem, who is made to pass through the transition rites under the diviner's guidance. It is of no importance if the client is not actually the ill person but instead is somebody representing him/her: the aim of the process remains exactly the same. From an initial normal condition he/she is in fact introduced to a separate ritual world from which he/she finally returns to his/her normal existence bringing with a heightened knowledge of the afflicting problem. The specific location of divination in time and space determines, as we have seen, this character of liminality, of being in transition between two worlds: it connects the profane time of ordinary space with the sacred time of the symbolic space.

The ritual of separation is marked by the divining apparatus and sensory mode. The divining instrument (mbugu) is first shaken by the muringia in order to shake up the society, particularly the normal condition of the sick person in it. The flow of events (the contents) in the normal world (the container) is recreated and reordered so as to be questioned. But to catch the right events in this flow the muringia needs a special sensibility, a power of vision beyond the usual sight. It is a figurative process rich in dreamlike images, metaphors, metonyms and

Fig.5.2 THE TEMPORAL STRUCTURE OF DIVINATION AS A RITE OF PASSAGE



synechdoches that Fernandez defines as 'figuring out the inchoate human condition' (in Peek,1991:218).

This transcendence of normal sight - which in other cultures is often associated with human blindness as among the Dinka (Lienhardt, 1970:68) - through divinatory vision offers the muringia access to a different kind of thinking, to a 'non-normal mode of cognition' (Peek,1991:199), a different realm of existence which allows him/her a better knowledge of the client's problem. This different type of knowing and the way it is communicated to the client are the two constitutive elements of the rite de marge. From his supersensitive condition the muringia offers the client a 're-vision' of his/her problem: but, at its beginning, it is still enigmatic because of a 'superabundance of understandings', an excess of symbols and possible interpretations that must be reduced to a series of consistent meanings. From a muddle of 'polysemic morphemes' embedded in 'multi-referent contexts' the diviner's duty is to produce 'meaningful metaphoric utterances' (Peek,1991:200). This is accomplished through the process of communication between the diviner and his client: the dialogue between them is crucial, as we have seen in Ndeke's case, in determining that the proper information will be selected for acting upon. Peek suggests that 'the key stage of divination is the dialogue generated by the oracular message' (1991:205), and the manner in which this is realized becomes really critical. It certainly implies a certain skill in communicative empathy on the part of the muringia in order to make an adequate use of his/her client's response, as we

have seen.

The last stage, the rite of aggregation, is marked by the decision-making process. Once a better understanding of the client's situation has been gained by a non-normal mode of cognition during the marginal state, it is time to return to the normal profane condition with a plan of action in mind. This is exactly what happens during this stage: 'For in the end, if the client is to be brought to act, if not efficaciously, at least with some confidence,a sequence of activity must be proposed to him. The 'cryptic potency' of the diviner's session , therefore, lies in its production of domesticated sequences of action out of wild, existential simultaneity of experience' (Fernandez,J.W. in Peek,1991:218). After temporarily shifting decision-making into the liminal realm of a different cognitive mode, the divinatory session necessarily ends up with a series of practical decisions: mainly, what to do, whom to go to for the recommended treatment. These practical decisions necessarily imply a sequencing, a linear chain of clearly stated actions,intelligible to the client (Parkin,1991:173). However, contrary to the Arab, Digo and Giriama diviners described by David Parkin, Tharaka aringia do not immediately pass from simultaneity to sequencing: by analyzing their speech, we can locate a liminal, atemporal (or sacred) phase of symbolical 'networking', during which a multi-dimensional structural causality is singled out by them. Simultaneity and sequencing characterize the opposite stages of separation and aggregation, when the normal temporality must be first twisted, upset and then completely restored.

In conclusion, if a divination session can be interpreted as

a rite de passage, it is because of liminal character that bridges two different modes of cognition, making use of both of them: sequential, logical, common thought and structural, intuitive, symbolic thought. The role of the diviner is exactly that of acquiring normally inacessible information by a non-normal mode of cognition, which is then synthesized with everyday knowledge in order to allow the client to make a plan of action. In doing so, the muringia acts as 'a translator between worlds as much as between modes of thought' (Peek,1991:202), as a structurally creative mediator. I personally agree with Fernandez when he suggests we should not overemphasize the mysterious elements in the 'cryptic synthesizing power' of the diviner (in Peek,1991:220): especially in the case of the Tharaka muringia, what appears important is his/her exceptionally sensitive capacity to mediate between two essentially different realms and ways of knowing. As again Fernandez puts it, 'the best diviners are the ones who are exceptionally well tuned into the primary processes where so many of our problems lie' (cit., in Peek,1991:202). The diviner is a liminal figure who has access to a different world: but there he/she stops. He/she cannot go beyond, to manipulate at will this realm: because this is exactly the professional duty of the healer.

FOOTNOTES TO CHAPTER 5

1) I agree with the redefinition of the contrast between the profane,secular and the sacred, mystical causation in terms of observable and hidden causality proposed by Skorupski (1978). Most of my work here is based on the dichotomy between visible and invisible world.

2) Since the late nineteenth century, in fact, anthropological approaches to non-Western belief systems were influenced by a strongly positivistic feeling that denied any idea of causality other than that based on verifiable observation only. In this respect, divinatory methods became merely 'survivals' in Tylor's work on 'Primitive Culture' (1871), while other early anthropologists, such as Frazer, scarcely mention divination. At best, when divination is considered as a different way of knowing, it is judged as erroneous - such as in the work of Fortune on Dobu divination (1932) - or 'detrimental to the intellectual and moral welfare of the Natives' (Junod, 1927:572). Only the two founders of French ethnology, Durkheim and Mauss, proposed an approach to the 'science of the diviners' as based on a particular system of classification of things (1901-1903). But their pioneering approach was not followed up by subsequent French scholars, especially Griaule in his work on Dogon (1948).
Nevertheless, the French school has produced some of the major classic studies on divination systems, such as those of Trautmann (1940), Maupoil (1943) and Delachaux (1946); more recently, important researches has been published by Retel-Laurentin (1969) and Adler and Zempleni (1972).

3) The questionable use of the typically Western dichotomy between magic and science when dealing with non-Western systems of beliefs and epistemologies has been strongly argued by Levi-Strauss (1966), Marwick (1973), and Zuesse (1987).

4) Among the most prominent studies on witchcraft proposed by the British school are those of Middleton and Winter (1963), Beattie and Middleton (1969), Douglas (1970), Marwick (1970), and Gluckman (1972).

5) In the first group, Devisch includes both psychological approaches stressing the therapeutic functions of divination (Beattie, 1967; Turner, 1975), and sociological models emphasizing social functions of divination (Middleton,1964; Harwood,1970; Gluckman,1972).
The second group includes those studies considering 'the expressive and explanatory function of divination, seen as a conceptual system, a system of thought, a way of knowing' (Devisch,cit:62). Even though this approach seems to be more promising than the first one, it does not come up to expectation in that it assumes Western science's principles

as universal, considering non-Western systems of thought as 'pre-scientific', 'illogical' and 'non-rational'. Consequently, the studies following this approach (Turner, 1975; Horton, 1967; Mendonsa, 1978) become 'the epistemological complement of the structural-functionalist interpretation of divination' (cit:62).
Finally, the third group includes those studies using a 'praxeological approach' (Young,1977; Werbner, 1973; Turner, 1975), which consider specifically the divinatory event, taking into account the various different types, with its own dynamics leading to a decision-making process. The value of this approach, according to Devisch, lies in its full acknowledgement of divination in itself, with its peculiar (linguistic, dramaturgical, etc.) characters, and not simply as a representation of the social order. In this respect, the divinatory event is not considered as the result of a non-logical behaviour, but as a means of expressing people's world view and 'cultural truths' in non-Western societies: 'A divination system is often the primary institutional means of articulating the epistemology of a people' (Peek,1991:2). Instead of considering divination systems as 'closed' ideologies founded on religious beliefs, we should look at them as open, dynamic systems of knowledge ordering the decision-making process in certain cultures. This could in fact explain why divination is chosen, in such cultures, by social actors as a means of selecting the proper course of action.

6) It is remarkable to note the actual scarcity of studies on divination by African scholars: among the few valuable contributions, there is the monumental work of Abimbola on Yoruba Ifa divination (1967, 1976, 1977) and a co-contribution by a Malgasy scholar (Verin, Pierre and Rajaonarimanana, Narivelo 'Divination in Madagascar: the Antemoro case and the diffusion of divination') contained in Peek's set of readings (1991:53-71).

7) African-based typologies of divination systems classically propose a dichotomy or a tripartite division of forms. Thus Devisch (1985:51-1)distinguishes 'interpretative','mediumistic' and 'oracular-interpretative' divination; Zahan (1983) categorizes diviners as 'interpreters' (intellectuals) and 'messengers' (mediums); Crawford (1967) proposes a tripartite division among 'psychic' (possession), 'psychological' (interview), and 'casual' (chance) form of divination. Of some interest is the opposition proposed by Peek (1991:12) between 'open-ended, analogical systems' (Ndembu basket) and 'fixed response digital systems' (Zande poison oracle). Substantially, all these classifications seem to agree on a distinction between those forms of divination involving possession states and those performed in normal states of consciouness: this appears as a formal distinction, since in both cases there is the presence of invisible forces that 'speak' through the divinatory apparatus (non-possession forms) or the diviner himself (possession forms). I agree with Peek when he

argues that 'All divination forms involve a non-normal state of inquiry which then requires a ''rational'' interpretation of the revealed information by the client if not by the diviner' (cit:12), suggesting that both the 'revelatory' and the 'analytical' dimensions of thought are present in divination.

8) I can argue that the different ethnic identity of Ndeke (since he is a Chuka and not a Tharaka, even though both belong to the wider group of Meru people) together with his Western-type education may have exerted some influence on his initial negative attitude towards the mugao Kinyua. However, the use of 'foreign' diviners - considered as more powerful - is common to many African peoples (Peek,1991).

9) The model I use here to represent Tharaka emic etiology is clearly derivated from Kleinman's model of reality (1980:28).

CH.6 'KUROGORA': COUNTERACTING THE EVIL

6.1 Theoretical Approaches to Ritual Symbols

The third component of health-seeking behaviour - therapeutic choices - is , as we have seen in Chapter Three, greatly influenced by medical expertise. Types of treatment and sources of treatment advice are, in fact, intimately intertwined: the opposition between materia medica and ritual behaviour includes the opposition between popular and professional spheres of knowledge. Which, in turn, is homologous to the opposition between a visible, 'natural' and an invisible, 'supernatural' etiology. We have, then, a patterning in which a visible etiology of illness remains within the popular sphere of knowledge and simply requires materia medica on one side, and an invisible etiology of illness requiring specialist, professional work mainly utilizing ritual therapies on the other side.

If we look at the latter, and place it in terms of the jurisdiction mentioned earlier, we find ourselves at the core of the mugao's activity. It is now time to explore the nature of his ritual behaviour. I shall try to accomplish this difficult task by analyzing the ritual treatments I observed during my apprenticeship as configurations of symbols. If the etiological classification supplied by uringia (divination) is firmly grounded in a symbolic order, inevitably the treatment system which stems from it should be approached in terms of

symbolism. I shall therefore define and analyze all ritual elements as symbols, and their complex configuration as a system.

At this point, before starting the analysis, I need first to define my concept of 'symbol' and my approach to the complex matter of 'symbolism' (1). I believe that symbolism is a phenomenon by means of which global values and emotions, both of a social and individual nature, are expressed and managed. From a semantic point of view, symbolism can be described as an inventive process through which a global and 'nebulous' code - a 'code of codes' - is outlined. The complex and varied meaning of a symbol is built up through a direct link (ratio difficilis: Saussure,1916) with the properties of symbolic expression (2).

It can be seen that, on one hand, an anthropological perspective is always 'symbolic' (in that it shows the interconnections within a single culture in its entirety, or in different cultures within a comparative perspective: Sperber, 1982); on other hand, in the case of ritual symbols the 'symbolic perspective' also belongs to the users of symbols themselves. There is, or at least there should be, a correspondence between the interpretative task of the anthropologist and what is carried out by people involved in the ritual (3). Indeed, in the ritual field, indigenous actors are encouraged to rebuild the fundamental semantic links which give meaning to their culture, in the same way as the anthropologist does (Sperber, 1974:58-59).

Nevertheless, considering as symbols the objects, the instruments, the actions, the gestures and the spells of the rituals described present some interpretative problems due to the complexity of symbolic meaning. The deeper semantic links are

unexpressed. The exegesis of the informants proves insufficient; what is more, it is sometimes contradictory in itself (4), and it can be contrasted to meaning of an 'operational' kind (5), in which social conflicts and emotions can appear, and to other informants' exegesis concerning the same symbol. Indigenous exegesis may not even give information about the meaning of a symbol: 'I treated that way because it is my habit and that is what our forefathers were doing since long ago' answered my master M'Mburuki many times in response to my insistent questioning (6).

In order to identify unexpressed meanings, one must, of course, have a fine 'encyclopaedic knowledge' (7) of the culture under examination; and one must follow certain paths according to the process of symbolic interpretation. The source of meaning must be compatible with the symbolic expression, characterized by its own formal properties. Starting from this , one can begin to construct, according to ratio difficilis, the symbolic meanings; at the same time taking into consideration the possible meanings the symbol already contains outside the ritual sphere. It is worthwhile remembering that semantic links tend to be built according to a binary code which defines semantic contents through presence or absence of certain properties, thereby establishing equivalences and oppositions. Symbolic significance of a complex nature may therefore be obtained through one or more series of semantic oppositions, connected by the presence/absence of the same semantic properties (Levi-Strauss, 1958). Different meanings are connected with different cultural sectors or

contexts, drawn together thanks to symbolic interpretation. This semantic association between different contexts, amounting to an association of a metaphorical kind, is considered by Leach as a characteristic of symbols (Leach,1976). As he shows, the 'leap' accomplished by semantic association which draws together different semantic areas may be transformed into a gradual passage by dividing the metaphorical associations into two metonymical associations, namely into elements belonging to the same cultural context (8).

The structural method briefly outlined above may prove of some use, but it needs to be adopted with care. First and foremost, meaning is never perfectly organized on the basis of a binary code. If it were to be so, it might be possible to create a cybernetic model of human thought. In reality, uncertain meanings exist, such as 'fuzzy' concepts (9), which have vague boundaries for all the members of a social group, and contradictory or imperfect meanings, which derive from the intersection of different semantic axes, from the clash of different opinions and projects, lying behind the immediate meaning of symbols, and from historical change.

The weakness of structuralist method also lies in its stress on the exegesis provided by indigenous informants as to their behaviour: verbal information is considered as a reliable source for tracing the deep mental structure underlying the organization of cultures. In so doing, one risks overlooking important elements that can give the anthropologist confirmation of the unexpressed or unconscious meanings he is looking for (10). A semantic association which remains verbally unexpressed can be

derived from an analysis of other expressive modes present in the culture. As Turner has perspicaciously demonstrated, the observable behaviour of the social actors often supplies a key to determine such unexpressed meanings (Turner, 1967).

With respect to the validity of unexpressed and deeper cultural meanings established by the anthropologist, we can further note that such meanings should derive from an exploration of different cultural domains; in other words, they should constitute a semantic content extensively displayed in the culture. The more we analyse different symbolic expressions and examine different cultural semantic fields, the more we can identify those 'overlapping' areas of meaning mentioned by Sperber (1974:46) in which basic and remote values characterizing a culture are found. A 'deep' meaning is thus confirmed only if several kind of symbolic expressions, belonging to different contexts, are related to it.

After all, the semantic structures identified through the structuralist approach do not exhaust the meaning of symbols. In reality, the meaning of symbols embraces different levels, which may be defined as levels of depth, but not of truth. As Marc Auge has pointed out, different kinds of logic determine the meaning of cultural elements, each with its own specific 'truth' (11). Each kind of logic possesses its own coherency register, which distinguishes it from the others: in fact, whereas the first (logic of differences) becomes the object of the structuralism, the second (logic of references) organizes the so-called 'social etiology', and the third (logic of events) is a

matter of history. In our analysis, the three sorts of logic distinguished by Auge will be kept in mind, together with Turner's approach, since they are useful for integrating the structuralist method. The equal importance which I attach to indigenous behaviour and exegesis will also allow us to ground the identification of 'hidden meanings' in both these two aspects.

The three dimensions of meaning elicited by Turner, namely the 'exegetic', the 'operational' and the 'positional' (Turner, 1971:126) will be followed as much as possible. Particularly, these will be tied in with Turner's useful distinction between 'dominant' and 'instrumental' symbols (1967). In Turner's definition, I shall identify dominant symbols found in different ritual categories as those 'relatively fixed points in both the social and cultural structures, (that) indeed constitute points of junction between these two kinds of structure' (Turner, 1967:31-2). We could say that dominant symbols constitute an important link between the order of references (the social structure) and the symbolic order (the cultural structure). Dominant symbols possess 'a high degree of constancy and consistency throughout the total symbolic system; ... a symbol recurring in a cycle of rituals is likely to have the same significance in it' (Turner,cit.): therefore, they have a general meaning, with ideological connotations, that remains the same in all the social contexts and with regards to all specific uses. In order to discover it, I shall examine this kind of symbols from a positional point of view, from the global perspective of the entire Tharaka culture. My aim will be to

discover, through the 'logic of differences', the semantic structure of the healing jurisdiction; and through the 'logic of references', the relationship between the above cultural structure and the empirical social order.

In doing so, I shall try to elicit, as far as possible, the polarization of meaning of the dominant symbols. According to Turner's definition, this is a characteristic of such kinds of symbols (12), that is found only indirectly in the instrumental symbols. In my opinion, all symbols have emotional meaning; but the sensorial meaning strictly termed as 'frankly, even fragrantly, physiological' (ibidem:28) is clearly identifiable only in dominant symbols, and not in all of them. The same can be said of the ideological meanings, which are only very remotely connoted by instrumental symbols.

In fact, the instrumental symbol 'must be seen in terms of its wider context,i.e., in terms of the total system of symbols which makes up a given kind of ritual. Each kind of ritual has its specific mode of interrelating symbols; ... each ritual has its own teleology. It has its explicitly expressed goals, and instrumental symbols may be regarded as means of attaining these goals' (Turner, cit.:32). Instrumental symbols are defined on the basis of the function they perform in the specific ritual in which they are used. For this reason, apart from their exegetic meaning (which is also presented in the analysis of dominant symbols), they need to be particularly examined in the context of ritual dynamics (operational meaning): in this way it should be possible to identify the specific 'ritual pattern'.

Unfortunately, the task of distinguishing the characteristic structural elements of each ritual category has only been partly accomplished, insofar as it proved impossible to collect a sufficient number of versions belonging to a single ritual category. Besides, the marked flexibility of Tharaka agao, and the presence of acculturative cultural elements of different origins in their rituals would make it hard to define a single group of characteristic symbols for each ritual category. Therefore, we shall limit our analysis of instrumental symbols to the specification of some particular elements for each ritual category, without any claim to be exhausting the whole ritual pattern. Our aim here is more general, and more strictly linked to the structure of dominant symbols.

6.2 Instrumental Symbols and Ritual Patterns

I shall start by presenting an outline of the instrumental symbols I singled out by examining all the rituals presented in Chapter Four (Chart 6.1). The comparative analysis of such rituals has in fact allowed us to identify a series of 'typical' symbols whose presence is significant only in a particular ritual category. I shall thus discuss them according to the meaning they assume in the ritual dynamics (operational meaning), taking into account their exegetic explanation. A few observations of a positional nature will be also made.

Chart 6.1 INSTRUMENTAL SYMBOLS

Ritual	Symbols
Mugiro	- nkooro - ng'ondu - rukuu - bundles of magombogombwe - 'cleaning'
Kibitana	- nkooro - ng'ondu - mpau ya kindaji - bunches of gakuri - nyambura - 'sweeping away'
Gendaga	- ucuru - cooking tools - njau - 'vomiting'
Kirumi	- goat's head - muthigu doll - kaugo - 'burying'
Urogi	- kirika and rurindi - knives/needles - 'hitting' - 'closing' - rurigi (rurigi) - 'stepping over'(rurigi) - body's parts (kio) - 'tying' (kio) - 'sleeping'

Kibitana

The main instrumental symbols for the ritual of kibitana are the instruments of nkooro, mpau ya kindaji, the bundle of gakuri and the medicine of ng'ondu; the action of 'sweeping' and the

concept of nyambura in the spell. Ng'ondu literally means 'sheep' and it is used to denote tha plant and the medicine prepared from it 'when the patient is unable to afford to buy a sheep' (M'Mburuki). The exegetic explanation shows that they are supposed to have the same symbolic and healing properties as a sheep. The latter, as well as the goat, is a sacrificial animal : particularly, it re-establishes the link with Murungu (God), the source of life, well-being and morality, who has been offended following the infringement of a norm of sexual behaviour.

The strips of goat skin or of the tuber named nkooro which are put on patient's fingers are also used during the segregation period of the initiation rituals (murindiru) to mean the 'rebirth' of the novice, in order to 'link' him to the a-temporal dimension of both the divinity and the ancestors (the sources of norms and values), and to his commitment to them to behave appropriately. In kibitana they have probably the same meaning of bringing the patient back to his birth, after a breach of moral rules: this allows him to reconsider his behaviour and restore his original commitment. They also probably makes visible the patient's condition of impurity and his redemption from it once they are taken off: 'When she has nkooro, it shows that she has evil; when nkooro is removed it shows that the evil is removed', Kigwato told me after the ritual. The use of the verb 'to show' here indicates the importance of this symbol in communicating a certain dynamic meaning to the patient in a comprehensive manner.

The bunches of gakuri (small plant) are instruments

specifically used to treat kibitana, moral impurity metaphorically symbolized as 'dirt': their function is therefore connected with the action of 'sweeping away' dirt, namely eliminating the impurity.

The mpau ya kindaji is a small gourd specifically used for treating kibitana. The emic explanation of Kigwato is that 'it is a child of nyambura, which never saw an evil thing because they are not yet adult, so that it helps a child to recover'. Thus, we should consider the two symbols as strictly connected: the pumpkin probably represents childhood, a condition of purity originating from a state of well-being, prosperity and fertility (what is termed nyambura). This interpretation is confirmed by the fact that the mpau ya kindaji played an important role in the ritual of 'social acknowledgement' of the new-born(Volpini,1978); while nyambura etymologically is derived from the noun mbura (rain), broadly meaning something good, bringing prosperity to living beings; and it particularly refers to circumcision feasts. The term nyambura is also used for menstruation, considered as a phase preliminary to pregnancy. In Tharaka language, the expression 'kuruta nyambura' means 'to ejaculate the sperm' in sexual intercourse, having a ritual and propitiatory value for fertility (Volpini, 1978:110).

Therefore, the overall pattern of meaning of the ritual category of kibitana seems to approximate to the structure of a purification ritual (Douglas,1970), in which the moral impurity symbolized by the nkooro is removed (the 'sweeping away' using the bunches of gakuri) by restoring a condition of purity like that of childhood (mpau ya kindaji), using a medicine (ng'ondu)

that recreates a link with the source of morality (God and the ancestors),allowing for the restoration of health, well-being and fertility (nyambura).

Mugiro

The main instrumental symbols for this ritual are the nkooro, the ng'ondu and the bundles of magombogombwe, the action of 'cleaning' and the concept of rukuu in the spell. As we can see, two symbols are the same as in kibitana: the nkooro and the medicine of ng'ondu. Therefore, we assume that the function they play is analogous: this suggests that we have again a purification ritual. In fact, the extensive meaning of mugiro is simply 'impurity': Tharaka people talk of the mugiro of kibitana to indicate a sexual impurity. So, how does it differ from kibitana? The absent symbols here are as significant as those present: the mpau ya kindaji and the concept of nyambura do not appear in this purification ritual, since sexual behaviour is not involved in the illness etiology. The impurity here is named rukuu, something that comes from the death of a relative in the home, a form of pollution acquired by physical contact with a corpse or with the dead person's personal belongings. Mugiro ya rukuu is therefore a death impurity that affects the dead person's relatives: it needs to be normally 'cleansed' by a series of behavioural restrictions (eating, movement,etc.) during a period of segregation, and by ritual sexual intercourse with an unrelated person that marks the end of segregation.

When this is not properly done, the ritual of the mugao must

be performed in order to eliminate the defilement: using the bundle of leaves of magombogombwe (the same function of the bunches of gakuri in kibitana), he repeatedly touches and sprinkles with the ng'ondu medicine the patient's body from different positions. In this way he connects, as in Kibitana, through the symbolic code used, the personal level (the illness) with the super-human world of the dead relative.

Gendaga

The main instrumental symbols for this ritual are muurugo and giiko (two cooking sticks), ucuru (millet porridge) and all the other types of food used as a medicine, the action of 'vomiting' and the cases of 'oddities' in the spell. According to the exegesis of the agao, gendaga means 'to eat an herb': since the herb is not edible, the expression is intended to indicate something eaten accidentally, by bad luck. According to Tharaka etiology, this is due to oddities which one can chance upon and which mentioned in the ritual spell: a person with one eye, a woman with two umbilical cords, people with scars, a disabled person. Twins (13) and an only child are also usually included. All these are considered strange things, being the result of either an excess or a short-fall of natural forces. They are deemed to display a situations of imbalance in the natural forces, and are bearers of a particular, extraordinary force themselves. Consequently, to meet them by chance in the early morning is interpreted as a sign that a particular accidental event will mark that day. According to the explanation I received by my master and his assistants, this is because these persons

have received certain njau - like Njiru (buffalo) and Njue (rhinoceros), both wild and violent animals - that are considered bad. The Tharaka concept of njau can be translated as 'totem', a natural protective force, a protector (14). It usually takes the name of an animal or of a star, like Njeru (Sun) and Nyaga (Moon).Since the njau is something inherited by a family (for the system of family inheritance, see Volpini, ibidem.), those people with bad njau are considered involuntary bearers of misfortune, causing accidents and illnesses. This is a fundamental difference between gendaga and the other illness etiologies, which all imply a will: of the sorcerer in the case of Urogi, of the cursing person in the case of Kirumi, and of the sick person himself breaking a social norm in the case of Kibitana and Mugiro.

If the extraordinary event that brought the illness in the Gendaga is, for example, something inedible eaten by the affected person, then the continuing, pressing exhortation in the spell to 'vomit' is a clear metaphor for the expulsion of evil, of the bad luck that brought about the trouble. In this respect, it appears extremely significant that the objects used to treat the sick person by the mugao are two cooking sticks (muurugo and giiko), and that the the ritual is performed near the fireplace: food preparation, meaning the normal flow of events in everyday life that was disturbed by Gendaga, must be restored to its usual form. The medicine that is used to treat the patient after 'vomiting', the evil is not the usual muthega as found in the other rituals, but a mixture of all the main vegetable foods eaten by Tharaka people, mainly based on the ucuru. This millet

porridge dish is extremely common in Tharaka and can thus be considered as symbolizing food par excellence. As such, it represents the natural forces in their ordered flow of everyday life; together with all the other kinds of vegetable food it represents the overall configuration of vital forces which are acting in the natural world in a situation of balance. The break in equilibrium due to an imbalance (either through loss or through excess) which produced the oddity that caused the ill fortune is thus overcome by the new balance of vital forces.

The overall configuration of symbols in this ritual pattern seems to give shape to a sort of ritual of 're-equilibrium' of natural forces, in order to re-establish the 'normal' flow of events, avoiding any sort of oddity. The symbolic codes implied here seem to connect particularly the individual level with the natural cosmos and its forces, explaining away any strange thing in the former's life by a lack of balance of the vital forces in the latter.

Kirumi

The main instrumental symbols for this ritual are the goat's head, the doll of muthigu, the spoken word used to curse (kaugo) and the action of 'burying'. The little doll prepared by the agao using the fruit of muthigu, in the exegetical meaning proposed by M'Mburuki, 'stands for the person who had cursed'. Its anthropomorphic resemblances,therefore, represent a person who is supposed to be dead, otherwise the curse would not be effective. Significantly, such a doll is used to bless the muthega for kirumi: exactly the opposite of the action the cursing person did

when still alive. In trying to explain the meaning of the goat's head we are faced with an apparent surplus of meaning: M'Mburuki, again, explains that it represents the cursing person, too. Why such superabundance of meaning? I can argue that the exegetical explanation, here, is at least incomplete: the little doll stands for the whole person when still alive, the goat's head represents his/her cursing part, which became effective only after death. It is the tongue of the goat that is removed and buried in the hole made into the ground. The ritual takes place near a hole where the patient is treated from different positions: the same position, one supposes, from which, whatever it was, the dead person cursed the victim. Thus, once again, the action which the causative agent is believed to have performed to produce the illness is re-created, to be then counteracted by 'burying' the part of the body (the tongue) that was used to curse together with the muthega. It is worth to noting that, traditionally, burial was not usually practised by the Tharaka; like other Meru people, they used to leave the corpse exposed for hyenas in the forest. Burial was reserved for particularly important dignitaries such as the Mugwe. This seems to suggest a particular importance was attributed, as part of the ritual, to the act of symbolically burying the tongue of the cursing person in the hole: in this way, its powerful effect is believed to be no longer active.

Finally, it is relevant to note that only the spoken word, kaugo, can effectively curse: 'Kirumi follows what the enunciator says...If he does not say what should affect you , you will not

be affected', said Rukungi. This means that the power of the curse is strictly related to the social, communicative effect of the spoken word: a curse which is not publicly expressed is ineffective. The social dimension is thus strictly implied here, particularly the relationship between young and older people when the latter are abused by the former. 'Kirumi follows mistreatment, because if I curse a person who has not mistreated me, kirumi is not effective', stated M'Mburuki. It appears as if the curse is a sort of weapon in the hand of the elders to be used in case of mistreatment by young people. But since the curse becomes effective only after death, the supernatural dimension is also implied, involving the world of the ancestors: therefore, we can say that kirumi links together the personal with the social dimension, and both with the supernatural one.

The overall ritual pattern of kirumi seems to be a sort of 're-blessing ritual' during which the cursing person (the muthigo doll) is evoked in order to counteract the effect of his publicly spoken word (kaugo) by 'burying' the body part that pronounced the curse itself (the tongue of the goat's head).

Urogi

This ritual presents particular problems since, as we have seen, it involves many subtypes (seven), each one implying a specific kind of sorcery. We have to distinguish the instrumental symbols common to all from those specific to each subtype. Regarding the latter, since the comparative material available does not allow for a complete analysis, I shall choose only two ritual sub-types as exemplars: rurigi and kio. In the first, the

main instrumental symbol appears to be the object of _rurigi_ and the action of 'stepping over and back'. The meaning of the piece of small string and its various accessories, all called '_rurigi_', lies in its property of 'binding' the victim once he steps over it as it lies hidden on the path, just as was done by the _murogi_ to 'bind' his victim and cause him to suffer from illness. The idea that the actual practice of burying a piece of string with other objects on the path can bewitch the person stepping over them is very common in Tharaka as elsewhere. The action of 'stepping over' the _rurigi_ and the patient himself by the _mugao_ during the ritual recreates this sorcery, according to the principle we could term 're-bewitching': Tharaka healers adopt the technique of re-creating the _urogi_ by using the same sorcery tools used by the _murogi_. This allows them to be able to exercise their power over them, thereby destroying their negative effect. In the case of the _rurigi_ ritual, this is obtained by repeating the 'stepping over' backwards and in the opposite direction.

The main instrumental symbols of the _kio_ sub-type of ritual are the different parts of the victim's body and the actions of 'tying' and 'sleeping'. The different body parts collected by the _mugao_ represent by metonymy the victim himself: they are tied together using the _miragwa_ leaves and hidden in different places where the _murogi_ is supposed to have done the same. The action of 'tying' implies a 'closure' of the victim, who remains submitted to the negative influence of the _urogi_. Once again the 're-bewitching' principle is applied by the _mugao_ in repeating the _murogi_'s action in order to counteract the evil and destroy it.

In the case of kio this is obtained by 'untying' the bundles the following day, meaning the 'opening' of the victim, whose body parts are freed from the negative forces evoked by the evil power of the murogi. It is worthwhile to note the importance of time in the dynamic of this ritual: this will allow us to understand the meaning of 'sleeping' on a positional level. The tying is done at sunset, to re-create the evil; the patient is left to sleep during the night; finally, at sunrise the patient is awakened and the bundles are untied, to imply a new healthy condition. The temporal structure is clearly that of a rite of passage: the patient moves from a condition of ill health (the separation stage), through the sleeping period of the night (the liminal stage) to a condition of restored health (the re-aggregation stage).

Finally, if we try to identify the instrumental symbols common to all the category of urogi rituals, I believe we can single out at least the objects kirika and rurindi, knives and needles; and the actions of 'hitting' and 'closing'. Knives and needles are usually mixed up with horns by the agao to perform the aggressive function of urogi: their formal properties of being pointed and sharp support this exegetic interpretation. However the explanations seem contradictory considering the fact that both knives and needles are also used for preparing the muthega, and the needle for injecting it into the patient's body. This apparent contradiction of their aggressive function can be explained in terms of ambivalence: they express both the characteristics and negative effects of the urogi and the power of ugao fighting against it. If the murogi has sharpened such

tools against his victim to produce illness, the mugao is even sharper in fighting this bad magic. Such ambivalence in meaning can be considered a typical phenomenon of the symbolic thought, in which objects and actions can 'condense' different or even opposed meanings, assuming different characteristics according to the will of the performing subject. This, in turn, is consistent with the principle of 're-bewitching' previously described: the action of the mugao against the evil may be represented and carried out by the same symbols used to re-create such a power.

In this respect, kirika and rurindi, the two sticks which are usually rubbed to make fire, can be interpreted in a similarly ambivalent way. They represent fire by metonymy: as such, they are tools of aggression used by the murogi to overcome his victim's power. At the same time, they can be used by the mugao to fight the evil and strengthen the patient's body. From a positional point of view, it is worth noting that fire is also used by the mugao to keep off the urogi's attacks in the 'inga mucii' ('closing of the household') ceremony, traditionally performed before the circumcision ritual (Volpini,1978:102).

The action of 'striking',using a knife or other objects, is clearly related to the aggressive function of such objects discussed above: but, as there, such meaning is ambivalent, since the aggressive action expresses both the attack of the evil and the action against it by the mugao. Of a more general nature is the meaning of 'closing' implied by most of the rituals of urogi by the actions of 'binding' or 'tying': the idea of

'closure' becomes here a metaphor for carrying out sorcery in general. Conversely, the mugao's actions of 'untying' and 'unbinding' represents the 'opening' of the sorcery, meaning the anti-sorcery action in general. This is probably the central pattern of the category of urogi rituals: to counteract bewitchment by the murogi, they first re-create it (re-bewitching principle) in order to destroy the evil forces evoked and heal the patient. The ambivalence of meaning implied in this important category of rituals has a particular value for the interpretation of the whole healing pattern of the Ugao.

6.3 Dominant Symbols

The main characteristic that distinguishes this kind of symbol is, as we have seen,their semantic 'openness', their usage in different contexts and ways of meaning with also different functions. Their meaning is not strictly linked to a specific ritual, as are instrumental symbols; they have a wider spectrum of references, of significata, usually linked by simple association. If so, their semantic polyvalence should allow us to identify some recurring values and principles that interrelate the specific domain of the Ugao with the other social domains in Tharaka culture. I first present a general overview of all the dominant symbols singled out through a comparative analysis of all the healing rituals in Chart 6.2.

Iraa (Diatomite)

In precolonial times, Tharaka healers used to cover

their body completely with this substance. Later they had to abandon this tradition, marking only their temples and eyebrows and, sometimes, their navel, so as not to be identified as 'witches' by British colonial authorities. Iraa is a symbol of the healer's totems (njau): Njeru, the illuminating power emanating from the sun, and Nyaga, the illuminating power of the moon; both representing in their turn the power of Murungu, the divinity. Therefore, they stand for the vital force by which Murungu lights up the world and the human beings, showing them the proper path to take to solve their troubles.

The association between iraa and light is thus based on the property of 'brightness';this makes it also possible to define it in opposition to darkness, and in relation to a series of homologous oppositions belonging to other domains of Tharaka culture. First and foremost, the opposition 'light/darkness' can be transformed in the equivalent oppositions 'visible/invisible', 'controllable/uncontrollable' and 'known/unknown': in fact, ideologically speaking,in Tharaka light means 'visibility', which in turn means what is known and kept under control; whereas darkness means 'invisibility', a condition related to what is unknown, uncontrollable and dangerous, and for this reason has a negative meaning (15).

Since I was told many times by the agao that the Ugao art must be performed during daytime, whereas the Urogi work is performed at night, we can add a further opposition between 'Ugao/Urogi'. This association between the Ugao and the known, controllable, visible world on one side, and between the Urogi

Chart 6.2 DOMINANT SYMBOLS

	Symbols	Rituals
MATERIAL	- iraa	- all
	- ndondo	- urogori
	- ngoci	- urogori, kirumi, gendaga, kibitana
	- mburi	- urogori, kibitana, kirumi, initiation oath
	- miti mikuru	- kibitana
	- uki/ruuji/nchobi	- all
	- nkio	- all
	- kioria/muthega	- urogori, gendaga, kirumi
BEHAVIOURAL	- 'delimiting a ritual space'	- all
	- 'making circular movements'	- urogori
	- 'touching all the joints'	- urogori
	- 'spitting'	- all
VERBAL	- urio/umotho	- all
	- kiama	- urogori
	- numeral seven	- urogori
	- sunset/sunrise	- uringia, urogori, gendaga

and the unknown, uncontrollable, invisible world on the other side is fundamental to the ambivalence central to the Ugao art: the ambivalence originates from a strict relationship between the knowledge of the visible and that of the invisible world implicit in the Ugao. In this respect, it becomes also extremely significant that the njau of the mugao are two and not one: they combine the knowledge of the evil (the darkness of the night illuminated by the moon, Nyaga) with the knowledge of goodness (the light of the day coming from the sun, Njeru). Instead, Urogi does not possess such an ambivalence: it must be performed during a moonless night. If we remember that in Uringia, divination, the sense used to identify evil is, then we can conclude that the mugao, once the invisible has been made visible in the divination process, has the specific task to control and manipulate it thanks to his proper esoteric knowledge of this invisible world and of its forces. Evil thus becomes good, illness becomes health, ill luck becomes good luck.

I shall examine in more detail the nature of this power in the next chapter; here, I shall add some considerations of a positional order. Iraa plays an important role in most initiation rituals, especially in the nguuru ya nguu, a ritual in which a child is socially acknowledged; it was celebrated some time after the birth. In it the baby's body was totally covered with iraa (Volpini, 1978:71). The presence of iraa in a context where a newborn is fully recognised as a member of the social unit, denotes iraa's association with social order and the continuing re-establishment of that order through the socialization of new

indviduals. Conversely, the murogi is considered an asocial person, whose work is carried out for anti-social purposes. The last two paired oppositions can thus be 'order/disorder' and 'social/asocial', denoting an important link between the Ugao and the social structure.

Ndondo (Red Ochre)

Red ochre is present in all the rituals included in the category of urogori and is used by the mugao to anoint himself with seven marks (particularly some body parts, like arms and legs) alternated with seven white marks of iraa. The interpretation of this symbol presents some difficulties: if the red colour is supposed to oppose the white colour to mean evil against good, why is not used black, according to the metaphors of light and darkness we have already found applied to iraa ? To solve this problem, we should probably keep in mind the polysemic value of colour in any social context (Leach, 1976:82), where meaning can only be understood in the dimensions of contrast with the other colours.

Thus we appear to have a dyadic classification, white and red. But is that really so? As Turner points out in his interesting comparative study on colour symbolism (Turner, 1967), a dyadic classification often conceals a triadic one. The absent member, black, is probably as significant as the ones that are present: Turner, again, argues that black is the emblem of what is secret, hidden, obscure, unknown, and, as such, as such dangerous to have manifest in itself. Therefore, the real opposition here should be between red and white on one side and

black on the other side. But what is its meaning?

We should remind ourselves that the red ochre in Tharaka was used in the elders' initiation ritual kiama gia nkubiri as a symbol of their power (Volpini, 1978:138), either for condemning someone to death or for preserving his life: as such, it is an ambivalent symbol, both of blessing and cursing, of life and death. Turner indirectly supports this interpretation by stating that the red colour is metonymically related to blood and hence to its ambivalence: it means life, as in the blood of childbirth and menstruation, as well as death, as in the blood of hunting, war, conflict, etc.. We can argue that, in the context of Ugao, red assumes the same ambivalent meaning, representing the power of the mugao to heal or to regenerate as well as to kill or to poison somebody.

This ambivalent power of good and evil implied by the colour red is confirmed by developing a positional analysis of this symbol. In the myth of origin from Mbwa, both Bernardi and Volpini's versions agree on reporting that, when Tharaka (and Meru) people had to cross the iria tune (literally, a red water large expanse) during the exodus, they did not pass over all together. They crossed in three groups: the first when still night - they are called Njiru (black); the second at dawn, -they are called Ntune (red); and the last one when the sun was already up, so that they are called Njeru (white). This distinction reflects a triadic classification of kinship groups still functional, at least partially, among Tharaka and Meru people. It confirms the liminal characteristic of the colour red, between

white and black and, hence, its ambivalence.

At this point, we can conclude that the juxtaposition of red and white marks on the mugao's body does not imply anthithesis but complementarity: when associated with the colour white, red ochre means the benign face of the power and the mugao's intention to act for good and for life. Therefore the opposition is that between this association of the two colours and the third colour, black. So what is its meaning ?

Positional meaning can help us once again. If we turn to the structuralist analysis proposed by Rodney Needham on the basis of the ethnographic material given by Bernardi, we find that the Mugwe, the religious figure and dignitary of the Tharaka and Meru peoples is associated with the colour black (Needham, 1960:20-33) because of both the black cloak he wears as one of his insignia, and of the ntigiri, the small bull sacrificed during the first phase of the ceremony of his investure. We know that the essence of his power is spiritual in nature, as opposed to the power of the elders, which is political in nature: we can hence conclude that the association between the colour black and spiritual power is present in Tharaka culture. We can now try to go further by tracing a semantic opposition between spiritual power, symbolized by the colour black, on one side and the political power, symbolized by the colour white, on the other side. Healing power, symbolized by the colour red, has thus an intermediate, ambivalent nature. The problem remains why there is an association of red with white in some Ugao rituals. The problem is clarified by what the mugao Kinyua told me during my apprenticeship: 'In matters such as kibitana or mugiro, you

should not mix white powder (with red ochre). But on matters of urogori you should mix the white powder'. Therefore, the ndondo is mixed with iraa only in the category of anti-sorcery (urogori) rituals, where human powers only are involved; whereas it is not used for the other ritual categories, where extra-human powers are involved.

Ngoci (Horns)

Horns are an essential part of the mugao's paraphernalia. Even though they are mainly used in the anti-sorcery category of rituals (urogori), they are even employed in other rituals such as kirumi and gendaga: thus, as we have seen, they are considered by Tharaka people as the emblem of the Ugao art itself. We can thus suppose that this dominant symbol has a general meaning that goes beyond the specific meaning each horn assumes in the ritual where it is used (a specific horn being used for a particular ritual). In order to get at such ideological meanings, it is useful to refer to the exegesis given me by the mugao Kinyua when explaining the use of horns and herbs together: 'it (the horn) heals a person because of these herbs inside...But if you use only those herbs alone without horns, a person cannot recover; he (mugao) must use them together with horns'. Hence, we can argue that the key is in the association of the horns with herbs: the former are used by the mugao to bless the herbs and to give the medicine to the patient once they are transformed into it. Moreover, as we have seen, the ngoci play an important role in the category of anti-sorcery rituals as instruments for the

'inversion' of sorcery. We can thus conclude that the herbs, as such, are considered empty, plain matter: in order to acquire their healing properties, they need the power of the horns to strengthen them. This is the reason why the herbs alone cannot make a person recover: they have no power in themselves. I shall examine in the next chapter the cosmological classification that lies behind this conception: here I want only to stress that the horns represent the healer's power to manipulate certain forces as such, and this is the reason why they take on the ideological meaning they have in Tharaka society.

We know that this power is ambivalent in nature, either for good or for evil: this is the reason why, during my apprenticeship, I was taught to treat them with care and I have always seen my master treating them with respectful deference. In the ritual of nkuuma ngoci (treating the horns), before handing over the horns to me as a novice, I was taught by my master that 'You will carry kioria separate from horns... You may go with a horn and it becomes dangerous: in that case, use the kioria which I am using to counteract the horns'. This seems to suggest that, while the power of the horns is ambivalent, the power of the kioria (medicine) is only good. Which inevitably leads us again to the triadic classification of colour: it does not seem arbitrary to associate the colour red with the horns (ambivalence), the colour white with the kioria (good) and the colour black with the muthega (bad). If so, we can understand why the agao told me to keep the horns separate from kioria, treating them with care: since if their ambivalent power turns harmful, you may still have a chance to counteract them using

the good medicine (kioria). Metaphors apart, the healer has power to manipulate certain forces for evil purposes, but he can always reverse the effect if he wants to do good.

Mburi (Goat)

The goat is considered an animal of special value in Tharaka culture, both economically (for bride-wealth) and ritually. The latter is especially due to its being used at feasts and in ceremonies. In particular, during initiation rituals it is the animal used for sacrifices to the divinity; moreover, it is eaten as a 'binding' element for an oath, and strips of goat skin (nkooro) are placed on the novice's fingers during the segregation stage to 'tie' the candidate to the ancestors and to the divinity as the general source of life and, as such, of societal values and norms.

Thus, the goat 'condenses' two fundamental meanings: on a sensorial plane, it represents well-being, vitality and prosperity; on a ideological plane, it means the binding power of the tradition. The two meanings are thus based upon the divinity and the ancestors'power. I believe that, in the context of healing rituals, the goat retains both these two positional meanings. A goat is sacrificed in a particular manner before a ritual whenever the patient can afford it. Its blood (thakame) and rumen contents (thunthuma) are added to the herbs used in preparing kioria medicine. The blood probably assumes here the same meaning of the red ochre, representing the vital power of the mugao and its ambivalence; the rumen contents enjoys

metonymically the same properties of the herbs the goat ate, according to the mugao Kinyua's exegesis: 'When you put the stomach contents inside here (in the kioria), the goats eats very many herbs, some too small which you could look for and miss them. Therefore, the good herb is there'. The goat's rumen is thus believed to have a great healing power because of the properties it absorbed from the large varieties of herbs the goat ate: hence, it can trasmit them to the kioria itself.

Apart from this sensorial meaning of vitality and well-being, the ideological plane is also present in the healing rituals of Ugao. The 'swearing on the goat' is, in fact, very common among the agao (see Chapter Eight for further details) and denotes a typical kind of brotherhood named gichiaro. This type of oath-taking is particularly present in the ceremony of the swearing-in of the novice, where he is being made to lick the ritual instruments dipped in the goat blood.

Other parts of the animal (the head, the lungs, the rumen itself) are then used for particular functions in some specific rituals (urogori, kirumi,etc.), where they assume specific operational meanings (see 'Instrumental Symbols').

Miti mikuru

This is a dominant symbol condensing a strong idelogical content. The term literally means 'ancient plants' (miti=plants, trees; mikuru=ancient), and denotes a bundle of sticks, four to six inches long, tied with one or more strips of goat's skin and containing in the middle a goat's foot and, in the past, a baboon penis. According to the exegetic meaning, this symbol represents

the unity of Tharaka people (union of the sticks), fertility (baboon penis), prosperity and wealth (goat's foot) in the stream of tradition and in mutual love (strips of goat skin). Thus, the global meaning of miti mikuru clearly illustrates the link between well-being and fertily on one side and the respect of social and moral norms on the other side.

This exegetic meaning is confirmed by the positional dimension of this symbol. In several initiation rituals miti mikuru serves the purpose of re-establishing societal norms as a source of well-being.In rituals of acknowledgment of the new-born in the society (nguuru ya nguu, see Volpini, 1978:71) the miti mikuru were also adopted as instruments for powdering the baby's body white. This action shows the symbolic association between iraa (diatomite) and miti mikuru: the right knowledge represented by the former is strictly linked to and based in the solidarity, fertility and well-being of Tharaka people represented by the latter.

In the healing field, miti mikuru is typically used only in the ritual category of kibitana. According to the exegetic explanation supplied by the mugao Kigwato after the treatment of kibitana which I observed, the reason for this is that this ritual is particularly performed to treat cases of sexual impurity that produce troubles in the sphere of fertility and child rearing, thus exactly the opposite meaning which the miti mikuru have.

Nkio (Fly-whisk)

It consists of a wooden handle with esoteric marks and a tuft of cow tail tied to it. It is worth noting that its positional meaning denotes the elders' authority in Tharaka society: particularly, their political power to 'whisk evil away' from society by punishing the people guilty of anti-social or immoral behaviour, in order to enforce tradition (Volpini,1978).

In the case of Ugao, the nkio is specifically used mostly in the ritual category of urogori with the meaning of 'chasing away' evil forces from the patient's body. Thus, it fights the urogi; it drives away evil, just as it drives away flies. In particular, it is used in the sorcery technique of mubarukio, consisting of objects or animals that are put inside the body of the victim. The fly-whisk is also useful to prevent the urogi: one can take it when one goes to visit somebody and hold it on one's lap during the meal. And, as the mugao Kinyua states, 'A nkio that is blessed prevents one from being bewitched. During the time of greetings a person, after greeting him (the host), holds the nkio with that hand (used for greetings)'. We can suppose that the blessing is the only real difference that distinguishes the nkio of the agao from that of the elderly: a difference that appears significant in a symbol which links once more, in its positional meaning, the power of the mugao with the power of the elder.

Uki (Hydromel)/ Nchobi (Sugar Cane Beer)/ Ruuji (Water)

Uki is a a drink obtained from honey and it is used for

blessing by taking a sip of it and spraying from one's mouth onto the object or the person to be blessed. This action evokes the beneficial properties and symbolic meaning of mbura (rain): hence, it connotes 'life', 'fertility' and 'well-being' in general. On the ideological plane, hydromel is related to the divinity and to the Mugwe, who used it to bless people. Uki is also present in the initiation ritual of the elder kiama gia nkubiri (Volpini, 1978:139) to mean their wisdom, which only allowed them to drink hydromel and other fermented beverages: in fact, having the power of transforming consciouness, it could only be drunk by people who were considered mostly mature. In the healing rituals, it retains the same positional meaning, being used to bless either the herbs, the horns, and the patient itself to symbolize his recovery.

Nchobi (local sugar cane beer), being a fermented drink like hydromel, shares with it the same connotation of 'joy' due to the effect it has on people when it was traditionally drunk during ceremonies, feasts and rituals. Unlike uki, it has no mystical reference to the divinity; it is used during the circumcision ritual, when the candidate drinks it in order to be admitted to the new age class of nthaka (Volpini, 1978:100).

Water is a vital liquid and, as such, shares with the first two liquids the same connotations of 'fertility' and 'well-being'; it has mystical connotation since it comes from the divinity, also named Ngai (rain), according to its Masai name. It plays a crucial role in the initiation rituals, especially kirimu and ntano, having the meaning of purifying the candidate. It is

also a symbol of unity of the clan and continuity of the tradition: 'Every clan has a ritual stream with which it identifies itself in a certain way. The ancestors celebrated their rituals on its banks' (Volpini, 1978:104).

In healing rituals water has the same meaning of purification, being particularly used in the rituals of purification from impurity (mugiro and kibitana). We can argue that the three liquids in the ritual context share a common meaning of blessing: a more mystical connotation, when using uki; denoting joy and feast in the case of nchobi; and a particular stress on purification when ruuji is used.

Kioria/Muthega (Medicines)

Kioria and muthega constitute the two names used to denote the mugao's medicines, even though there is some lack of definition and overlap in the day-to-day use of these terms. Sometimes ndawa is also used: however, this is a kiswahili word, and, being an introduced term, tends to denote the more recent drugs of Western-type. Even the differential use of the two terms 'kioria' and 'muthega' is not clear-cut: most of the agao use them to distinguish the medicine obtained from ashes of baked herbs (muthega) in form of black powder from the thick paste obtained by grinding and soaking the herbs with water, and then mashing them together with thakame (goat's blood) and thunthuma (goat's rumen). Yet, in answer to my direct question, my master M'Mburuki disclosed me that 'When we say that we have given a person muthega, we imply that we have given him kioria. But muthega alone is that of urogi... The muthega of ugao is to

treat, therefore it is kioria to treat muthega of uroqi'.

We can thus conclude that this is probably the correct esoteric meaning, distinguishing kioria kia mbiro (the black powder usually called muthega) from kioria kia makie (the thick paste); even though, in the common terminological language, a less rigourous habit has come into use. We can also argue that, unlike ndagwa, both kioria and muthega act mainly because of the mugao/murogi's power and through the specific preparatory rituals. This opinion is also supported by the fact that the 'baseline' composition is the same for kioria in any kind of ritual, and the only variation is the addition of a few further specific herbs. Moreover, at the end of each ritual, the kioria kia mbiro is usually given to the patient in a horn or calabash to drink, thus showing the importance of the container's power. Then, the remaining part is sometimes applied to the patient's body through some superificial cuts made by the mugao using the mukua (needle). In contrast, kioria kia makie is usually given to the patient to anoint himself with. Kioria kia mbiro is usually baked in an half broken pot marked with iraa: this is probably to distinguish it from the normal pots used for cooking. Once again, the container is as important as the contents.

We can thus conclude that the curative properties and action of the kioria stems from the blessing the mugao has put on them: the herbs themselves can contain some 'natural' properties, but they need to be activated by the healer's power through the blessing. The spell used by the mugao for blessing the kioria in all the rituals is significant; as the mugao Kinyua explains

it:

> 'When you go and uproot the herbs in the bush, you come, put them down here, you take the white powder (iraa), you spit saliva and say to them: 'You were bush herbs, I came to separate you from the herbs of the bush, from the bush. I bless you as muthega, be of nyanjo, be of the kind of kibitana, be of ng'ondu'' (Int. 2.d.1, p.17).

The power of kioria is no longer simply the power of the bush herbs: since the mugao has blessed them calling them 'muthega', they are now something different. The nature of kioria is thus believed not to be the same as that of an herbal concoction prepared by lay people: its nature has changed because of the mugao's blessing and of the power it expresses. This creates a sort of 'alliance' between the mugao and these herbs in order to make them act properly for their specific task:

> 'The good herbs that are in love with the one uprooting and the patient, the ones being handed over this half-broken pot (rugio), may he be in love with them' (See 4.10).

An alliance that is expressed in the same etimology of the term kioria: its root -oria is the same as that of the verb kworia, meaning to heal, the action expressing the mugao's power. Kioria is thus the means of this action, literally meaning 'the thing that heals'.

'Delimiting a ritual space'

This action is variously carried out by the agao: some use simply a mat, others a string such as that of rurigi, others a series of stilettoes and feathers. Whatever the objects used, their meaning remains the same, being the structure of a mucii, a house, whose boundaries delimit the 'inside' from the 'outside', the separated space of the ritual from the normal space of the

world. This clearly makes possible it to create a new dimension inside this space, making the evocation of occult powers possible. But the house is not closed: a small 'door' is usually left at the feet of the patient. It is the entrance that allows the patient to re-enter the normal world, but in a new healthy condition: thus suggesting the possibility of achieving a new state after having expelled from the 'house', through the same 'door', the evil that afflicted the sick person. This exegetic explanation is confirmed by the similar role played by the 'ritual hut' actually built up in some initiation rituals such as the gatang'a (Volpini,1978:87-89).

'Spitting'

This action represents a traditional act of blessing performed by elders only. It is not really a spitting but rather a sprinkling of saliva onto the object of blessing. The beneficial quality of the spit comes from its quality of vital liquid of the body, like blood and sperm. The action is exegetically related to rain and to its value of fertility and vitality.

In the healing context, the action assumes a more specific meaning, related to 'frightening' away the evil, as the mugao Kinyua told me: 'I spat to make the muthega frightened and going out, as it was frightened when I clapped my hands'. Spitting is thus not simply associated with blessing, both being opposed to cursing; but it is also opposed to sorcery (muthega). In this respect, it is significant that the action of spitting is performed not only by the mugao but by the patient, too: in many

rituals, after licking or swallowing the kioria, he is made to spit, symbolically expressing the expulsion of evil by spitting out saliva. The horns help this expulsion, insofar as they are believed to attract and destroy evil, thanks to their ambivalent nature.

'Touching all the joints'

This action represents the only way by which the patient's body is handled by the mugao, who usually do not touch any other part. The joints, in the Tharaka concept of the body, constitute a dynamic element which allows the necessary strength. As the mugao Rukungi told me, 'When the body is affected, all the joints of the body are affected. The joints are the ones that make a person able to walk to another person's home, and if the body is too flexible, you have no strength to walk'.

This concept of 'body flexibility' brings to mind a Dogon belief, according to which the 'non-flexible body' (i.e., a body with joints) is a typical feature of man, which enables life on earth and work (16). According to what I was also told, the joints even represent the parts of the body through which the positive or negative forces can enter or go out of the body itself. Therefore, by touching them, the mugao's intention is to expel the evil forces and introduce the positive, vital ones to help the patient to recover. This action can be carried out by the mugao either with empty hands or by using an instrument (a horn, the flywhisk,etc.).

An apparently contradictory action is sometimes performed by

the agao when they take the patient's fingers and toes and crack them one by one. The symbolic value of this action lies in the semantic properties of cracking, exegetically meaning 'loosening' and 'freeing' the joints from the evil power of the uroqi which 'ties' and 'stiffens' them. We can thus conclude that the evil forces can manifest themselves either by making the body - through the joints - too flexible or too stiff: in both cases, the mugao's action is aimed to restore the balance of dynamics and static forces in the body, either by touching or cracking the patient's joints.

'Making circular movements'

This action is usually performed in all the anti-sorcery rituals of urogori, but it is also found in other ritual categories such as kibitana, and in the blessing of horns and kioria. It is in practice carried out in many different ways: by circling the patient, by making circular movements around his head or other body parts, pouring kioria all around him, etc.. Its exegetical meaning lies in a familiar principle: re-creating the causes of evil in order to destroy it. This is achieved by the mugao by subdividing the circular movements into two steps: first, there is usually a series of full circles performed in a certain direction; then, there follows a series of semi-circles in the opposite direction. The first action is a typical sorcery, since it 'imprisons' the individual inside the evil: it can thus be considered as a repetition of it. The second action is related to anti-sorcery, since it allows the patient, through the 'exit', an opportunity 'to make the evil flee' towards the outside. In

this process, the direction onto which the circles and semi-circles are performed is absolutely relative: the sequence can either be first clockwise and then anti-clockwise or the opposite, it does not matter. What really matters, here, is the opposition of the two steps, of the two cycles of circles/semi-circles: the healing process is conceived as a way of re-creating and then destroying the evil forces that afflicted the subject causing his sickness. The circular movements marked out in alternate directions represent the re-make of evil first and then its destruction. This general principle of ugao is grounded on the conviction that evil, the cause of sickness, must first be evoked and represented in order to be fully understood and finally destroyed.

Kiama (Magical Rite)

The Tharaka word 'kiama' comes from the preposition kia (of) and the noun ama (truth): thus, it literally means 'of the truth', implying somebody telling the truth or doing something true. According to Volpini (1978:28) the term has three different meanings in Tharaka culture: 1) council of elders (kiama gia akuru), 2) elderly age-class, such kiama gia nkomango, denoting also the related initiation rituals, and 3)ritual oath, such as in the expressions 'receiving a oath' (kunenkerwa kiama), or 'giving a oath' (kunenkera kiama). I agree on the triple meaning, but on the basis of my direct experience I think that the third meaning can better be translated as 'magical rite', since it denotes the whole ritual complex, whereas, when Tharaka people

want to indicate the oath strictu sensu, they use term muma (or gichiaro, if it is a brotherhood oath).

What do these three different meanings have in common ? In my opinion, they share the constricting power of the word and of the actions the word produces. Among Tharaka, as among other African people, word means 'effective power', to the extent that the spoken word also 'does'. The word has a real effect on things and people. In particular, the most effective words are believed to be the 'right'ones, spoken according to certain ritual rules, outside the everyday communicative context and in relatively secret situations: there is thus a series of characteristics common to the Tharaka councils of elders as well as to initiation rituals and to the spells in healing practices. Regarding the councils of elders, the words spoken during their judgments were the expression of their political power: a power with constraining effects both on the convict and the people who had to put it into practice and on elders themselves. With respect to the initiation rituals, the words spoken during the oath by candidate has the power 'to bind' him to carry out what he swore to.

In the domain of the Ugao, the word kiama denotes the spells as well as the practices and instruments which are equivalent to the spell itself. The words pronounced during the spell have the same constraining power either on things (medicines, horns,etc.) or individuals (such as the witch or his victim). But what distinguishes the use of the word 'kiama' in the context of Ugao is, once again, its ambivalent meaning: kiama is the murogi's bad magic and the mugao's good magic as well. In Rukungi's words:

'The murogi too, when he is bewitching, uses biama: these are removed by the mugao when treating a person. Even the mugao, when treating, calls them biama because it is a kiama that he does saying, 'May he/she die that way'. If a mugao happens not to know these biama well, he cannot treat a person to recover' (Int. 2.d.2, p.8).

The fundamentally ambivalent nature of the mugao's knowledge and work is confirmed: his power is the power of killing,thus it can really be dangerous. There is a sentence that recurs several times in the spells of different rituals: 'Gutiri kiama, murigwa imuma chionte' (lit. 'There is no kiama, I swear by all the oaths'). This is explained by the mugao Kinyua thus:

''Kiama,there is no kiama, and I have given you nthenge (he-goat)'. That is, you are talking to these herbs...(and) if they fail to do what I am saying, may they be afflicted by all the oaths. Because when you are eating a goat, you are putting the thunthuma (rumen contents) and thakame (blood) into it (the herbal medicine)...Therefore, you are talking to these herbs that they should not cheat you and fail to recover a person... But this is the real kiama...To say 'All the oaths, is to say 'The oaths which you swore with these herbs' (Int. 2.d.1, p.17).

The exegetical explanation is consistent with the meanings attributed to all the symbols implied: kioria, the nthenge of the oath, the kiama itself. The word 'kiama' here is used in the negative meaning of sorcery, bad magic: because of the oath which the mugao has sworn with all the herbs in the kioria (symbolized by the goat's blood and rumen he has put inside it), he can call them to counteract the kiama of the murogi (who did the same, but for the opposite purpose). The sentence 'Gutiri kiama, murigwa imuma chionthe' is probably used to convince the patient as to the healer's powerful medicine and its positive results: 'This is the real kiama' seems to show the mugao' s wish to stress that this is the real nature of his power, the real value of his

medicine.

Number 7

It is a very common symbol, recurring several times expecially in the category of anti-sorcery rituals: seven marks are put on the horns or other ritual instruments, the circular movements are often repeated seven times, etc.. Its meaning appears obscure: in order to grasp it, we have to consider it as composed of numeral four and three. The former represents a series of goodness in Tharaka culture as elsewhere in Africa (for example, among the Nandi, the number'four'seems to be sacred, according to Mbiti, 1969:56) : the seasonal alternation of rainy and dry seasons, the consequent rhythm of agricultural work (seeding and harvesting), the opening of circumcision periods every four seasonal cycles, the initiation of elders every four circumcision periods, the duration (four days) of the segregation period of any initiation ritual. Therefore, ideologically speaking, this dominant symbol connotes the structural order of Tharaka society.

The number three has no explicit meaning either in Tharaka culture in general or in the Ugao specifically. This creates a problem whose nature is probably analogous to that of colours. The absent symbol, here, appears as meaningful as those present. In fact, the number seven has a specific meaning related to the marks made on the horns: as Kinyua explains it, 'That (horn) for seven (marks) is for treating all kinds of urogi' (Int.2.d.1, p.7). This is confirmed by what my master told me about the existence of seven types of urogi, describing each of them. Can

we conclude that seven is the numeral representing the Uroqi? Probably, its meaning is more complex, representing the fight of good (number 4) with evil whose number is not specified, but, in order to express difference, we can suppose it is 3. This numeral should probably be associated with the colour black, both meaning uroqi, black magic. In which case, the number 7 can be considered an ambivalent symbol just as can the colour red; since it contains both good (4) and bad (3) numbers, it can thus be used either for doing good or evil things. Alternatively, we can argue that, given how Coastal medicines and cultures influenced Tharaka Ugao, even the meaning of number seven was acquired from Coastal cultures, which, in turn, were highly influenced by Muslim culture.

Sunrise/Sunset

The two directions are often pointed to by the mugao as he holds the nkio (flywhisk) or any other object (such as the calabash with the muthega). This action can be explained by referring to what the mugao does and says during the preliminary prayer before a ritual. He makes a gesture with his right arm tracing an arc in the air from the eastward to westwards,while he says: 'Njeru, owner of whiteness, as you rise, rise from the origin and go, go with all evil things, leave what I would like' (Int.2.d.1, p.2). So, the enlightening power ('whiteness') of the totem Njeru is invoked in order to assist the mugao in overcoming the patient's illness, just as the sun moves from dawn to sunset bringing 'all evil things' with it. The gesture and the words

of the mugao symbolizing the movement of the sun represent the work of the mugao himself: from the initial ill condition, he has to make the patient recover by chasing away all the evil forces. In this respect, the sunrise, East, represents the direction from which the evil comes: 'the murogi bewitches facing the direction of the rising sun' (Int. 2.d.1, p.14). On the other side, the sunset, West, represents the direction towards which all evil things disappear. This seems in some way to contradict Needham's classification of Meru symbolism (1960), in which he associates the East and the sunrise with the right side and the West and the sunset with the left side. According to our ethnographic data, both the sunrise (East) and the sunset (West) are related to a meaning of 'passage': from darkness and its invisible and uncontrollable powers to lightness and its visible and controllable powers, and vice versa. The evil which comes from the darkness thus disappear in the direction towards which all evil things disappear. This seems to suggest, once again, an ambivalent meaning instead of a clear-cut dual opposition.

Urio (Right)/ Umotho (Left)

The right/left opposition is a recurring symbol in many healing rituals to denote the male (right) and female (left) side. This opposition plays a crucial role in Tharaka culture and in Meru culture as well, and it was already examined in the famous article Rodney Needham wrote on 'The left hand of the Mugwe' (1960). In his analysis of the structure of Meru symbolism, he pointed to the 'practically universal privilege' of the concept of right, with reference to the wide literature on

the subject (1960:20). He affirmed that, since the right hand is the stronger, it tends to represent the masculine part of the society, and the political power this part generally possesses. Therefore, the opposition 'male/female' becomes homologous to 'right/left' and, particularly, to 'right hand/left hand'. In fact, the hand metonymically represents the person as a whole, insofar as it reflects his/her activity: even a murogi, can bewitch merely by 'sleeping with the hand of the woman or the hand of a man'(Int.2.d.1,p.5).According to the series of symbolic oppositions homologous to the right/left opposition elicited by Rodney Needham, in Meru (and in Tharaka as well) culture both woman and the Mugwe, the religious dignitary, belong to the 'left side' and its attributes. And woman. like the Mugwe, is connected with the colour black: at the end of the segregation period following the excision ritual, the woman receive a black iron ring (Volpini,1978:124).

We can conclude then with Needham's semantic chain, which included on the right side of the opposition, among other things, the male, the elders and the political power; and on the left side, the female, the Mugwe and the spiritual power. We could add the homologous pair of oppositions 'white/black', incorporating Needham's list which only mentions 'black' (attributed to the Mugwe), since the only element Needham had in this respect was probably the colour of the cloak (black) which the elders had in common with the Mugwe (Bernardi,1958:92). This created a contradiction which Needham himself recognized (1960:203).

In the context of the Ugao, it seems there is no

specifically representative hand: the mugao can use either the right hand (to anoint himself, to bless the patient,etc.) or his left hand, when for example he is treating a woman. This suggests that the Ugao art cannot be locked into the opposition right/left, but it probably has an ambivalent, ambidextrous nature.

6.4 The Healing Pattern

To conclude our detailed analysis of the dominant symbols in Tharaka Ugao, we need a synthetic picture of the structure we have till now been building block by block. When we start linking up the different 'meaningful oppositions' we have discovered in various semantic areas, we find two chains of metaphorical associations based on a series of metonymical oppositions (Chart 6.3). Apparently, the chain seems consistent and logical; it also fits in with the symbolic structure Roodney Needham discovered when analyzing the problem of the left hand of the Mugwe (1960). However, not everything appears so coherent; some elements do not fit at all. Firstly, there is the problem of colours: as we have seen, there is the problem of ntune, the reddish (brown) colour of the ndondo (ochre). Where shall we locate it? Secondly, the association of the Ugao with the right hand (urio) and of the Urogi with the left hand (umotho) is not satisfactory: this would imply some sort of symbolic correspondence between the Ugao and the political power of the elders on one side, and between the Urogi and the religious power of the Mugwe on the other side. But this clearly appears forced.

Moreover, we have seen that the mugao can use either the right or the left hand, according to what meaning he wants to attribute to his gesture. Finally, there is a set of symbols such as the number seven, the kioria/muthega, the horns, sunset/sunrise as the proper time for divination, whose fundamentally ambivalent nature or transitional state hardly fits in a dualistic logic.

Chart 6.3 CHAINS OF METAPHORICAL ASSOCIATIONS

urio	umotho
white	black
day	night
visible	invisible
known	unknown
light	dark
good	evil
right	left
male	female
elders	Mugwe
political power	religious authority
Ugao	Urogi
health	illness

If the meaning of the dominant symbols we traced is correct, there are two possibilities:either the dual classification is not

consistent or, at best, incomplete; or the cognitive logic behind the system is coherent but its structure is a different one. I am inclined to believe that the second hypothesis is more correct. Besides, Needham himself puts forth some doubts about the dualistic nature of the symbolic classification he discovered: he presumes, in fact, that the triadic classification of clanship system reported by Bernardi in the myth of exodus from Mbwa probably 'means' something (Needham,1960:23) on the ground of its being consistent with a series of other contexts in which the number three acquires a special meaning - such as in the three age-sets of the age-class system (Bernardi, 1959:35). But then, following Bernardi's ethnographic report about the elders'opinion among the Imenti regarding the fusion in one group of the red and white clans (17), Needham chooses to take a system of dual classification through to its conclusion.

I believe that, at least in the case of the Tharaka Ugao, a triadic classification would be more suitable: in fact, it would allow for a more comprehensive structure of the symbols used.In Chart 6.4 I try to sketch the framework of such a triadic classification on the basis of the symbolic correspondences I have found. I want to stress the point that, in my opinion, this is a purely cognitive structure (18): to shift from this symbolic order to a societal one is a problem of a different nature, one which requires a search for analogical relationships between cognitive structures and social structures. This is certainly a fascinating and intriguing task, as Needham's suggestions about the hypothetical ancient structure of Meru

society (1960:33) show. It would also probably allow us to explain the mysterious and apparently contradictory triadic classification of white, red and black clans contained in the myth of exodus from Mbwa. However, this sociological and historical analysis is beyond our scope here; we shall limit our considerations to the symbolic order and its implications for the Tharaka Ugao.

Chart 6.4 TABLE OF SYMBOLICAL CORRESPONDENCES

umotho	urio
female	male
night	day
black	white
black clans	white clans
number three	number four
Mugwe	elders
religious authority	political power
unknown	known
illness	health
evil	good

ambidextrous
androgynous
sunset/sunrise
red
red clans
number seven
mugao/murogi
healing power
secret
kioria/muthega
kiama

I am convinced that the main value of this triadic cognitive structure lies in the opportunity it offers to locate exactly each symbol we analyzed. In fact, it is possible to draw from it that a dual classification does not account for the ambivalence which is typical, as we have seen, of the mugao and his work in Tharaka culture: an ambivalence better classified as a transitional zone between the two other, opposed poles. A transitional zone marked by a series of symbols of ambivalent nature, such as the androgynous performance of the mugao during the rituals, the ambidextrous use of his hands during them, the periods of passage from day to night and vive versa (sunset/sunrise) as the right time for divination and Ugao rituals, the colour red associated with such periods (19), the number seven as a symbol of the ambivalent nature of power, the duality of kioria/muthega as material realization of this power for producing health or illness, the kiama as a polarization of will towards good or evil, the secret (witho) as 'hidden knowledge' in-between the known (common knowledge) and the unknown. The whole series of meanings points to the ambivalence of the role of the mugao/murogi, an intermediate one between those played by the elders on one side and the Mugwe on the other side. His healing power is somehow different from either the political power of the elders or the religious authority of the Mugwe. This finally reveals the real nature of this figure, solving the unresolved question that troubled us during our discussion of people's health-seeking behaviour in Chapter Three. If the triadic classification is correct, it discloses what

people in the depths of their minds really think but cannot say: the murogi does not exist. It is simply the other face of the mugao's work. The dark side of the Ugao. The double nature of the mugao/murogi appears evident.

But the validity of the triadic classification is not simply that of a static cognitive structure: it fully allows us to locate the central metaphor of the Ugao within its framework. It is a metaphor whose nature is essentially dynamic, as we have seen for each ritual pattern. Like that, it is mainly expressed through the symbolic actions of the mugao's performance: among the dominant symbols, I can argue this is represented by the circular movements in opposite directions (clockwise/ anticlockwise or vice versa) which the mugao makes during almost every ritual. By such gestures, he first recreates the evil and then destroys it. I am convinced that this dynamic of 'repetition/inversion' represents the central pattern of the Ugao. It is well expressed in the terminology used: 'kuroga' is the verb used for the action of repeating the bewitchment, whereas 'kurogora' is the verb that indicates the action of inverting the effects of the former. Therefore, 'kurogora' cannot be simply translated as 'to treat': it involves first a repetition of the action which the causative agent performed in order to do the evil; only after that is it possible to reverse its effects.

This sort of homeopathic/allopathic mixed principle contains a temporal structure of its own. The rhythm of repetition/inversion is a pendular rythm of the type Edmund Leach

has so well described as peculiar of transitional rites (Leach, 1976). It implies a possibility of reversing the flow of time, swinging from profane to sacred time when the inversion becomes possible. After the divinatory session has made it possible to get outside the flow of events in order to give events a proper explanation, the mugao can fully display his art by manipulating the temporal (now, atemporal) flow. The dynamics of repetition/inversion is then supported by the other symbolic actions the mugao performs. By delimiting a ritual space the mugao creates the proper place in which to operate. Spitting as an act of blessing and touching all the joints as a way of transmitting the mugao's healing power are then the necessary correlates to guarantee the success of the dynamic repetition/inversion.

The mugao can put into action this dynamic because of his liminal condition: his transitional state allows him to come and go back between the other two poles. But how is this work 'translated' into healing? How can it be really effective? And what is the source and the nature of this healing power? This is exactly what I intend to discuss in the next chapter.

FOOTNOTES TO CHAPTER 6

1) The problem of the definition of symbols and symbolism is anything but clear and agreed: definitions often are vague or else restricted to specific meanings of the term. As Eco (1976) has perspicaciously shown, the term 'symbol' can mean many different things; and definitions are thus contradictory and not exhaustive. An excellent example of restricted definition is the one put forward by Pierce: according to him, a symbol is something related to a precise meaning by common consent (1903:140). By this definition, the symbol is a label whose meaning is valid only in particular cases; whereas in most cases a symbol is something holding several indirect meanings, to be revealed.
Freud (1899) deemed it possible to work out a code which would provide a precise meaning for symbols, whereas much critical thought suggests symbolic meaning is always partly determined: Freud himself found difficult to eliminate the contradiction between individual and collective meanings fixed by his code. Eco argues paradoxically that the more powerful a symbol is and the more 'significant' it is, the more obscure and inexpressible its meaning becomes (1984:225),while argued Jung that symbols are related to the 'unknown' (1969:484).
Firth (1973) stressed the indeterminate nature of the meaning of symbols, and hence individual freedom in the process of their interpretation. The distinction between sign and symbol is generally based on this freedom of interpretation: it has been variously defined in terms of the opposition 'arbitrary/motivated' (Piaget,1945; Turner,1967), or 'known/ unknown' (Jung,1969), 'reference/condensation' (Sapir,1967), 'meaning/function' and 'meaning/emotion' (Lewis,1980).
On the other hand, it has been pointed out that all definitions of symbols imply that a symbol 'stands for' something else, and that this is the general property of signs, too (Eco,1984:130-3): any entity which is related to something else on the basis of an underlying cultural rule is regarded as a sign in Eco's semiotic theory. In this case, where does the specificity of symbols lie? Neither in the motivation alone nor solely in their indeterminacy: there are 'motivated' signs which cannot be defined as symbols (a geographical map) and, on the other hand, not all indeterminate signs are symbols (the process of significance defined as 'undercoding' of a foreign language). There is, in fact, a third very important feature of paramount importance, according to Eco: the specific 'semantic-pragmatic' attitude of the interpreter. It is the interpreter - either an individual or a culture - who on certain specific occasions decides to treat a sign as a symbol. This can happen in this way. When it is not created ex novo, through a process of an inventive kind, an expression is isolated from its ordinary context and interpretation. Then certain properties are deliberately linked to a new and 'nebulous' semantic content by exploring the 'cultural encyclopaedia'. The new meaning,

intuitive and inexpressible, can be explained as the result of a 'short circuit' in cultural codes; as such, it can be partly reconstructed and made explicit by tracing, step by step, the semantic passages which have been 'skipped'. The definition of symbols as an inventive phenomenon includes and explains the presence of particular idiolectic meanings as well.

2) It is another important feature of symbols, regarding the relationship between expression and content, pointed out by de Saussure (1916:86-7). This relationship, sometimes called 'motivation', is termed '<u>ratio difficilis</u>' when the expression and its semantic content are connected by common properties: the expression has in itself a trace of its meaning. On the other hand, when there is no property in common between the expression and its meaning, their relationship (defined as 'arbitrary') is called '<u>ratio facilis</u>'. Therefore, de Saussure distinguished a 'sign' - as characterized by an arbitrary relationship between expression and meaning, established solely on the basis of precise and explicit consensus - from a 'symbol', which has a 'natural' and motivated link with its meaning.
It is worth pointing out that this 'natural' relationship - as de Saussure and others defined it - is always culturally established, since the perception of a 'natural' likeness between formal and semantic properties of a symbol is attributed by a given culture. Even if universal meanings deriving from natural elements can be found, meaning is always culturally derived, and not a 'natural' process.

3) This coincidence also arises from a core methodological feature of anthropological work: the basically emic perspective from which the anthropologist looks at people's culture from an insider's point of view. This identification of the anthropologist with the local people, however, cannot conceal the fundamentally etic purpose of his work.

4) Sperber (1974) has clearly demonstrated that the interpretation of a symbol, in its turn, needs interpretation, and this process may be an infinite one. An example he quotes from Dorze, an Ethiopian people studied by him, is their belief that 'a leopard is a Christian animal which respects the fasting ordered by the Coptic Church' (cit:92). This apparently contradictory belief is explained by him in symbolic terms as expressing 'moderate eating' opposed to over-eating represented by hyenas. He suggests that at the source of this potentially infinite interpretative process lies the semantic contradiction expressed by a symbolic proposition and the belief holding it as truth.

5) As is known, Turner (1971) elicits three 'dimensions' of the meaning of symbols, linking together informant's behaviour and speech: 1) the 'exegetic' dimension, based on indigenous etymology ('nominal basis'), culturally selected natural and material properties ('substantial basis'), and properties acquired by the symbol after it has been worked upon

('artifactual basis'); 2) the 'operational' dimension, based on ritual participants' use of a symbol and their behaviour towards it; and 3) the 'positional' dimension, based on the relationship of a symbol with other symbols used in the same ritual category or in other cultural domains.

6)?Gilbert Lewis, in his pregnant essay on ritual (1980), argues that it is more appropriate to talk about 'function' with respect to symbols rather than 'meaning': the message of the symbols can be forgotten, but their use is maintained in society as an element of social identity and continuity. According to him, the way symbols are used is more important than the meaning of symbols themselves, and tends to be invariable. The organization of rituals, and hence of symbols, underlines social obligations and roles: they establish the rules in an oral society. Therefore, rituals and symbols possess great 'social strength'(ibid.:266).
In my opinion, the great power of certain symbols and their fixed use show, on the contrary, an indeterminacy and hence, 'openness' and potential richness of their meaning. If a symbol is powerful, it is probably because it can condense various meanings and represent the values and emotions of several people, without being restricted to a precise meaning.

7) Dan Sperber (1974) has strongly criticised the semiotic concept of symbols arguing for the impossibility of talking about significance with respect to them: in fact, he defines symbolism as a 'cognitive device' which maintains and puts 'between inverted commas' propositions with defective conceptual content, or a content which is in contradiction to the cultural encyclopaedia. In this way, 'the condition which is responsible for the initial defect' becomes the new focus of attention, preventing a deeper analysis of its contradictory contents and becoming a belief: another area of the cultural encyclopaedia is evoked and explored in order to eliminate contradictions and clarify the obscure points that lies at the origin of symbolism, satisfying the need to maintain a unitary foundation of knowledge and establishing 'true interpretations' or beliefs.

8) The construction of meanings through semantic oppositions and metonymical steps , almost in the fashion of a mathematical problem (Leach, 1976:7), has tended to encourage scholars to build semantic structures, according to criteria of order and coherence, thereby overlooking cultural reality at hand: the resulting structures have frequently been highly systematic, but useless as tools for understanding the cultures under observation.

9) A theory of 'fuzzy concepts' has been proposed by Lakoff (1972); see also Eco (1976:147).

10)Leach states that the stress placed on indigenous information is characteristic of the 'rationalist (structuralist)' method

of analysis, whereas the main aim of the 'empiricist (functionalist)' method is that of recording 'directly-observed, face-to-face behaviours of members of a local community, interacting with one another in day-to-day activities' (Leach,1976:4). He argues that both methods are useful, and that 'the principle that we are all the time dealing with a "single interacting whole" is easily forgotten' (ibid.:3).

11) According to him, the following types of logic exist: a) a 'logic of differences, which arranges the symbols (which enables the conception of social domain and form the intellectual framework of it), ... by means of equivalences and oppositions'; b) a 'logic of references, which establishes the possible (conceivable) relationship between the above-mentioned symbolic logic and the empirical social order'; c) a 'logic of the event,...which subjects the sense relationship established by the logic of differences and the logic of references to the evident relation of forces disclosed by history' (Auge and Herzlich,1983:53).

12) Turner elicits three properties of symbols: 1) 'condensation', by means of which 'many things and actions are represented in a single formation' (Turner,1967:28); 2) 'unification' of disparate significata; and 3) 'polarization of meaning'. While the first two properties are derived from the condensation property pointed out by Freud (1899), the third one was originally elicited by Turner, who identified two poles: the sensory one, grouping what is 'expected to arouse desires and feelings', and is related to 'natural and physiological phenomena and processes'(Turner,ibid.); and the ideological one, grouping social rules and values.

13) Traditionally, among the Tharaka, the second twin was killed: this apparently barbarous custom can be explained with reference to ethnological literature. Victor Turner (1969) has pointed out the aspect of excess of fertility, producing physiological, economic and terminological difficulties in kinship classification because of the substantiallly homologous identity of twins. Monica Wilson has spoken of twin birth as a dreadful event for the Nyakyusa: the parents and the twins themselves are considered <u>abipasya</u>, the dreadful ones, since they are believed to affect with sickness their relatives,their neighbours and the cattle, should there be any contact with them. Even among the Abaluya of Kavirondo described by Gunter Wagner (in Forde,1954:45) twinship is considered one of the deviations from the normal order of things which are thought to be fraught with dangers of a mystical nature.
Conversely, other peoples tend to consider them as sacred: it is the case of the Lele who, according to Mary Douglas (1966), deem them as a source of fertility; or the Nuer, who consider them as a go-between between man and divinity (Evans-Pritchard,1940); or, the Dogon, who see them as the perfect combination, the ideal unity (Griaule,1948).

Finally,the Fon of Dahomey consider a dual divinity,Mawu-Lisa, at the head of their pantheon: it is described as a pair of twins simply in order to express the unity and the dual nature of the forces at the basis of the organization of the world; but sometimes it 'is expressed more definetely by the conception of an androgynous, self-fertilizing being.(...) The notion of twin beings ... expresses the equilibrium maintained between opposites, which is the very nature of the world. The ideal birth is a twin birth (P. Mercier, 'The Fon of Dahomey, in Forde {ed.},1954: 219). I think the best conclusion can be expressed by John Mbiti's words: 'I would suggest that since the birth of twins is something extraordinary, something out of the normal rhythm of things, it gives rise to a feeling of extreme consequences: either consequences of misfortunes, and hence the necessity to kill the children (and their mother if need be), or consequences of unusual powers and hence the need to treat such children with special care or respect' (Mbiti, 1969:117).

14)According to Volpini (1978:52), the njau does not mean the animal itself (since they are termed differently in every day language), but the vital force represented by it. For the system of family inheritance of the njau, see also Volpini (ibid.).

15)The value of 'visibility', used with this meaning, can be found in many other African cultures (Davidson,1969); particularly, among the Ndembu, the ability to 'make something visible' is what defines ritual symbols, representing the interpretative and organizing basis of reality (Turner, 1967).

16)The body's flexibility, according to Ogotemmeli, was acquired by the blacksmith mommo-ancestors when he descended onto the earth: before this event, the blacksmith, like the other mommo-ancestors, had a flexible body, with snake-shaped limbs (Griaule,1948).

17)Conversely, Laughton (1944:2) states that the red and black clans were to be merged in one group.

18)Turner (1967) goes further by suggesting a 'biologistic' interpretation of the triadic classification based on the universal human experiences of the body: maternal milk and sperm (white), blood (red) and faeces (black). The superorganic is strictly related to the organic, through consciousness of intense physical emotions.

19)We can remind that, in the Tharaka myth of exodus from Mbwa,it is told that the second group of people crossed the sea at sunrise, and they were called Ntune (Red).

CH.7 'KWORIA': THE POWER OF HEALING

7.1 Healing as Power in Tharaka Cosmology

The last element of the health-seeking process I proposed to analyze was 'adherence', namely 'the degree to which the sick person acts upon treatment advice' (Chrisman, 1977:371). As I suggested, the sick person's evaluation of therapeutic effectiveness is an important element in shaping (or re-shaping) the patient's behaviour: it represents what I termed a 'fourth-order categorization' in the cognitive structure of illness held by people.

This immediately brings us to the long-discussed problem of 'therapeutic effectiveness' and of the 'anthropology of healing' in general. The literature on the subject is often unsystematic and still unsatisfying; as Kleinman puts it:

> 'The chief research questions are straightforward and have been known for quite some time: Is indigenous healing effective? And if so, how? What role do cultural factors play in bringing about the efficacy? (...) Yet, while the questions are clear, the answers are not. What we now possess are impressions, anecdotes, unsystematic findings, and strong opinions.(...) I wish to stress the inadequacy of our present understanding of the healing process' (Kleinman and Sung, 1979:7).

This unsatisfying 'state of the art' is probably due to the complex issues involved in how we evaluate therapeutic efficacy: which constitutes a central problem both in the cross-cultural investigation of healing and in the study of indigenous professions. However, we can completely agree with the statement that,

'Anthropological studies of therapeutic outcome are in a

very early stage of development. Lack of progress in determining the degree of success of traditional therapies, however, has not precluded analysis of how those therapies might work. Indeed, despite the inability of researchers to determine definitive outcomes, the very fact that people continue to have recourse to such forms of treatment suggests that they produce some kind of effect, and it remains relevant to search for definitions of that efficacy' (Csordas,T.J. and Kleinman,A. 1990: 18-19).

One of the first scholars who dealt with the problem was Levi-Strauss in his famous article on 'The Effectiveness of Symbols' (1). An interesting reconsideration of the issue of catharsis which Levi-Strauss argued must be at the heart of symbolic healing, is proposed in Atkinson's article bearing the meaningful title of 'The Effectiveness of Shamans in an Indonesian Ritual'(2). Of some interest for the problem at issue, is also the paper of Daniel Moerman on the 'Anthropology of Symbolic Healing' (3). One of the few attempts 'to systematically follow-up patients treated by an indigenous healer in order to determine,first, if this particular form of indigenous healing is effective; and,then, how it might work' is the follow-up study of patients treated by a shaman (tang'ki) in Taiwan conducted by Kleinman and Sung in the context of their larger study of Chinese indigenous healing (Kleinman and Sung,1979:7). The authors, in their discussion of the research findings regarding particularly the case of Mr.Chen, draw attention to the fact that the answer to the fundamental question: 'What is healing?', is somewhat different for the patient (and perhaps his family), the practitioner and the researcher (4):

'Indigenous practitioners in Taiwan believe most cases are successfully treated, since few return for treatment, and they believe failure to return is an indication of treatment success. This runs directly counter to the popular patient's viewpoint that you don't return to the same practitioner if

you derive no therapeutic benefit' (cit.:21).

After this short excursus in the still sparse literature on the problem of therapeutic effectiveness, I shall try to locate the problem within the specific cultural context of Tharaka, positing the centrality of the cultural notion of efficacy for any evaluation of healing. This implies first an important consideration: it is not my intention to demonstrate here (or invalidate) any 'cure'. Simply, following a 'persuasive approach' (Csordas and Kleinman,1990:21), I wish to stress the importance of 'cultivation of expectant faith through the personal influence of a healer of the ideology of the healing form' (cit.). In this approach, if 'the primary effect of therapeutic process is to transform the meaning of an illness for the sufferer' (cit.), the role which the emic concept of efficacy plays is deemed essential both in determining a patient's behaviour and evaluation of the cure he received and, as a consequence, in strengthening or not the healer's position and his relationship vis a vis the patient.

Tharaka culture does not possess a term for 'health' strictu sensu in the western biomedical meaning of 'something having to do with the physical well-being'. Tharaka people generally use two terms for 'health': 'wega', and 'inya'. The first word can better be translated as 'welfare', or 'prosperity': thus, it refers to the sphere of social and economic condition. The second word literally means 'power', 'strength', 'ability to do something'. Consequently, none of the two terms implies physical well-being in itself: a healthy person is somebody both prosperous and forceful, able to impose his own will over somebody or on something (5).

For our purposes, this second term for 'health' is the more meaningful one: in fact, it sheds light on our problem. To understand the full meaning of the kitharaka word inya, we need to know the Tharaka cosmological view of the universe. They in fact believe, as do the other Meru people as well, that the universe has a dual division, consisting of the 'visible' and of the 'invisible' world: the two worlds include seven levels of existence (6). In both the two worlds there is a dynamic power conceived as inya, the ability to do something. The word inya is qualitatively attributed to Murungu, God, who is also referred to as 'mwene inya', the owner or possessor of power, the Almighty. He is considered as the real source of power and, as such, capable of doing everything. As one of my elder informants told me,

> 'Murungu has all the power (inya): the power to give us children, to give us rain, to give us food, to give us wealth, to heal the wombs of barren women, to send away sicknesses, to remove evil, to cure illnesses, and to fight the spirits' (Conversation with M'Mutia M'Rimboya).

This power is then subdivided among the other six levels of existence in a hierarchical order. Nkoma cja bajuju, the ancestors, are believed to possess intermediary power, by virtue of their status, either to intercede on behalf of the living to protect them from misfortune or, if neglected, to make them experience sickness and death.

Nkoma, the hostile spirits, are deemed to have a subordinate power to do evil because of their vengeful and destructive nature. Apart from their power to do evil on their own, they can communicate the same power and knowledge of doing evil to

arogi (witches and sorcerers).

The human realm is subdivided among the leaders, the specialists and the lay people of the community. The religious leader is the Mugwe, who has power in religious, social and political matters,invested in him by Murungu to lead, protect and bless his people. Akuru ba kiama, the elders of the council, have power in social, political and (partially) religious matters: they rule the people, they control their behaviour, and they conduct sacrifices to God and the ancestors. The specialists have the knowledge and the technique to tap and manipulate the power for either benign (aringia, aroria, agao) or malignant (arogi) motives. Finally, lay people have a power either to bless or to curse through the spoken word, kaugo.

In the natural world, animal and plants are believed to possess a 'natural'power either for good (animal fat) or for evil (poisonous plants), which specialists are able to use for their benign or malignant purposes (7). The non-living things have no natural power in themselves, but the specialists who use them can imbue them with a power, as in the case, for example, of a mugao using iraa (diatomite) and ndondo (red ochre) to anoint himself and his horns before giving treatment in order to enchant his medicine to heal effectively.

To sum up, in the Tharaka cosmological view each of the six living ontological categories (apart from objects without biological life) possesses a certain degree of inya, conceived of as power, a dynamic force, an energy. Murungu is the source and the ultimate administrator of this power, the nature of which is unique and unitary. This is why I avoided using any adjective

to qualify inya, such as 'mystical' or 'magical'. These are both western categories which are not to be found in Tharaka culture: their concept of inya as 'the ability to do something' is always the same whether it is applied to political, religious, or medical affairs. The only recognized distinction, in the unitary view of this dynamic force, is the possible duality of its effects: it can be used for doing either goodness or evil, according to the positive or negative nature or attitudes of the ontological category having access to it. The powers that operate for the well-being of the people are believed to be those of the nkoma-cja-bajuju, of the Mugwe, of the akuru ba kiama, of the specialists such as the mugao, muringia and kiroria, and lay people when bestowing their blessing. The powers that operate for the ill of the community are those possessed by nkoma, arogi and lay people when they enunciate a curse. In all these cases, doing evil implies intention, a desire to do so by the agent pursuing it. The only exception, in this respect, is that of the non-human living beings, plants and animals, the powers of which can be exploited for good or evil according to the will of the agent using them.

It is beyond my intention to discuss here the nature of the power the Tharaka call inya: to see whether it can be considered in terms of Tempels' 'vital force' or rather approximates what in classical anthropology is called 'mana' (8). What matters here is that there is a specialist, the mugao, who is considered as such because of his knowledge and technique for tapping, manipulating and using inya in the sphere of human illness,

misfortune, and death. This ability is not innate: it can be acquired through a process of apprenticeship. This is one of the reasons why this specialist capacity can be considered a profession. By such acquired knowledge and techniques, the mugao is able to have access to the invisible world where the source of the power is located. In fact, before starting any ritual treatment, the mugao appeals to God through his two totems Njeru and Nyaga in order to associate himself with this force: in his prayer, he asks them to assist him in the ability of doing good and driving off all evil. During the performance of the ritual of urogori for the patient Kanyamu, the mugao Kinyua, while making the seven circular movements around the woman, repeats: 'Umbikire inya' ('Give me strength').

I believe that the Tharaka notion of 'inya' adequately accounts for the emic explanation of what is considered to be 'effective', 'efficacious'. The transitive verb used to define the action of healing is 'koria': it implies a power, an ability by somebody to heal someone else. It refers to the power the mugao has, through his acquired knowledge and technique, to manipulate the invisible forces that lie behind this power for the benefit of the sick person. The recurrent act of touching all the patient's joints during most of the Ugao rituals makes this power visible, representing it as a transmission of energy to the suffering body. No doubt this can happen because of the patient's belief in such power: as Levi-Strauss himself puts it, 'It is clear that the effectiveness of magic implies the belief in magic' (1963b:162). As the French anthropologist points out, this belief shows three complementary aspects: the belief of the

specialist in the efficacy of his techniques; the belief of the affected person in the specialist's power; and the trust of the community as a whole. In this respect, the experience of the patient in itself can be considered as lying between the two poles which define it: the collective consensus and the specialist's performance. We can say that the therapeutic effectiveness of what is going on, in the emic perspective, is the result of this triadic relationship between healer, patient and community. In fact, it is this relationship that structures and supports the patient's belief in the healer's power within its larger world view; it is just such a relationship that legitimates, at least traditionally (as we shall see in Chapter Ten), the mugao's activity. This is also the reason why any ritual performance is public: everybody can attend it, in constrast to what occurs when the murogi's is at work; this is performed in a solitary place during a moonless night.

I can conclude by adding that the therapeutic effectiveness of what we have discussed up to now should probably be considered in terms of what Moerman defines 'general medical treatment' (1979:59): it is the helping relationship based on the therapist's believed power that represents the essence of the treatment and, at the same time, the reason for its effectiveness. This does not exclude the mugao prescribing, for any specific ailment, a suitable concoction or herb for the patient, as M'Mburuki does at the end of Ndeke's treatment. But, once again, it is the patient's trust in the mugao's power that properly 'heals', with the help of more specific treatments.

I wish to put forward here a general interpretative hypothesis regarding the nature of the therapeutic effectiveness of the Ugao's art: the metaphorical structures, the system of meanings which we have previously traced by analyzing what we have called the specific 'ritual' and the general 'healing patterns', can all affect the patient's general condition by a subconscious process of communication rooted in the specific cultural context (9). The metaphor, used by the mugao, of the journey the sun does from sunrise to sunset bringing all evil with it, is a symbol of this out-of-awareness process of communication, of the path the patient's subconscious is called to follow.

The hypothesis has an essential correlate: that the problem of therapeutic effectiveness can be articulated at different levels of analysis by the researcher. Following Kleinman's suggestion presented above (1979), I think we have to distinguish, when evaluating cure, among various criteria of efficacy and different definitions used for them. The levels of effectivenness can probably be at least three: the 'technical' level of the effects of the treatment on patient's physiopathology (symptoms and signs); the 'personal' level of these effects on patient's general psychological state (emotions, feelings, psyche); and the 'social' level of the same effects concerning patient's changed role behaviour, identity, social control or relief of interpersonal tensions. Where it exists, we should probably add the 'para-normal' level of any extraordinary effect, such as production of objects, ecstatic visions, etc.. In our context, the three levels mentioned above seems to be enough

in order to study therapeutic effectiveness as the result of the intersection of different planes of analysis that goes well beyond the pure physiopathological changes. A correct anthropological approach, using an etic definition of these levels, should try to distinguish what is inextricably linked in the human reality in order to unravel the complexity of the treatment. A comparison with the emic concept of 'therapeutic effectiveness' becomes then essential to this process in order to locate in the proper cultural context the real meaning of,and any evaluation of what is socially defined as, 'medical treatment'.

7.2 The Semantic Structure of the 'Ugao' Jurisdiction

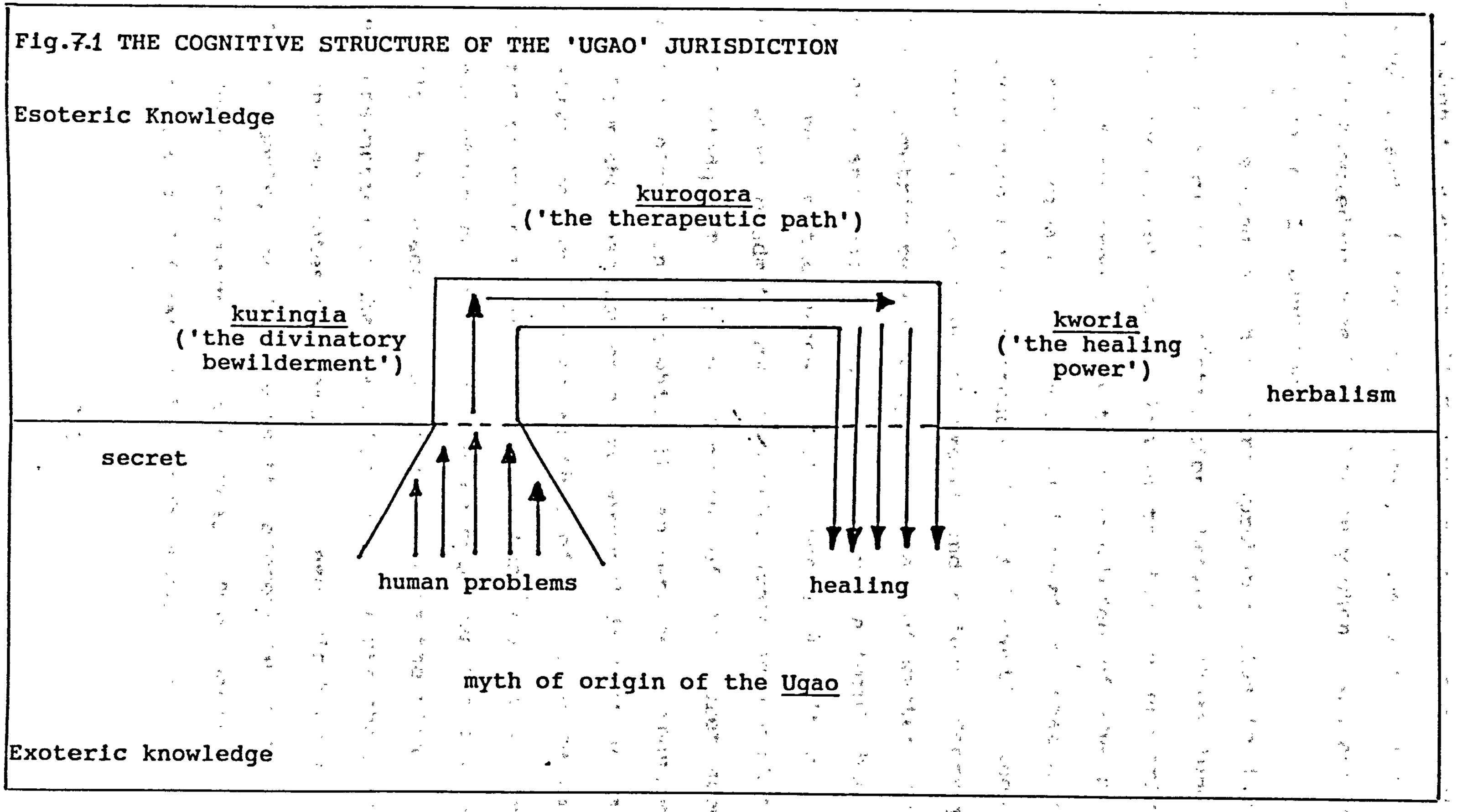
To end up our long ethnographic description and interpretation of what is the traditional medical expertise the Tharaka call 'Ugao' and how it works in people's minds,we need to synthesize the different cognitive segments we have up to now examined one by one (kuringia, kurogora, kworia) in a more comprehensive way, giving a proper definition of them. There are two main terms for 'power' in kitharaka: one is 'inya', the meaning of which we have already explained; the second one is 'unene'. It means 'power' in the sense of 'kingdom', 'authority', 'bigness', 'jurisdiction'. This last meaning suggests the idea of a certain sphere of human reality under the rule of somebody: and this is exactly the role the expert knowledge of the mugao plays in Tharaka 'medical' domain. The 'jurisdiction of the Ugao' is the metaphorical kingdom of this

expertise and of the rule it exercises over people health-seeking behaviour. It is the province of meaning over which the mugao holds his recognized authority.

If we have to try to define the concept of 'jurisdiction' in more etic terms, perhaps an appropriate definition could be that of 'a recognized authority over a certain domain'. Assuming this definition works (as I think it does), we now need to understand what distinguishes a jurisdiction like that of the Ugao from other types of jurisdiction (political, religious,etc.). This brings us to the problem of defining the whole cognitive structure of this jurisdiction (fig.7.1).

The first key element in this structure is the secret, witho, that envelops the mugao and his activity. What is its meaning? I shall start my answer by telling a story about my field experience. In the early days, when asked about my name, I was always disappointed at seeing people's reaction to my answer: in fact, they hardly kept a sneer off their lips. Later, I came to know the reason for such an apparently unpolite reaction: in kitharaka, there is an almost perfect phonetic homology between 'witho' and 'Guido'. And in fact, one day I received a letter from a local person that started like this: 'Dear Mr. Witho, ...'. I decided to exploit the funny coincidence by joining in the game: having become 'Mr. Secret', I thought it would be easier for me to approach the agao and their secret knowledge by joking about it. But any effort was useless: the secret (the real one!) was tough enough, the wall

Fig.7.1 THE COGNITIVE STRUCTURE OF THE 'UGAO' JURISDICTION



too high to step over. This gave me an exact perception of the solidity and of the importance of the secret surrounding the mugao's knowledge: something that only when I was accepted as a novice could I overcome.

The meaning of this secret probably lies in its function: creating a clear-cut distinction between those 'who know' and those 'who do not know', thus protecting the esoteric knowledge of the first from the exoteric knowledge of the second. This distinction creates, in fact, the foundations that give rise to a jurisdiction: the existence of a differential knowledge that produces the two roles of expert and client. Secrecy surrounds this asymmetric relationship with a halo of mystery that creates deference and fear. Moreover, this gives a formidable instrument of control in the hands of the specialist: it allows him to select whom to admit into his craft, avoiding a vast diffusion of his knowledge. This second function of the secret seems evident in the initiation oath which the apprentice is required to take.

From the description of my personal initiation oath (4.2), its structure can be seen as that of a 'rite de passage': the separation stage is marked by the ritual killing of the goat; the liminal phase consists of the oath-taking strictu sensu; and, finally, the re-aggregation stage includes the final dividing up and consumption of the goat. Such ritual marks the passage of the gate that separates the realm of esoteric knowledge from that of lay people, and introduces the apprentice into the previously forbidden territory of the Ugao. The oath-taking is the preliminary qualification for such passage: by making the

candidate aware of his new condition, it allows him to join the group of his masters, binding him to a lasting promise of solidarity (the type of brotherhood the Tharaka call 'giciaro'). We shall examine more deeply the wording and the meaning of the oath in Chapter Eight.

But what happens to the lay people, all those who are excluded from entering the land that represents the domain of the Ugao ? What are the cognitive and behavioural consequences for them of the existence of such jurisdiction? When a human problem can be properly solved by ordinary people themselves, that is indeed what they do: through the use of an appropriate techinique, the problem is dealt with and solved. When such problem is, for example, a simple ailment, its resolution implies the use of materia medica of an appropriate kind by a Tharaka lay person, whether a traditional concoction or some modern drug. But when such a problem does not disappear, it is at this point that, according to the Tharaka way of thinking, it becomes amenable to expert service. It is time to look for a muringia (or a mugao doing uringia) who will hold a divinatory session. This can be considered (as we have seen in Chapter Five), as a 'rite de passage', a journey the muringia makes between two worlds, two modes of thought. The result it produces in the client is a sort of 'divinatory bewilderment' by means of which the subjective becomes objective, the unknown known. Particularly, the subjective qualities of the human problem which the sick person has brought up, are translated by the divination session into the symbolic language of the muringia and acquire an objective quality: the meaning of such a symbolic etiology, even though it

is not fully understood by the patient, is a familiar label socially recognized and legitimized.

Here the muringia's journey ends: on the threshold of a different world he does not know how to manipulate. Her duty is just to show the way the afflicted person should follow: but she cannot escort him on such a way. This is precisely the mugao's duty. By means of his knowledge and of a technique made up of spells, objects and ritual actions, he becomes the travel companion of the patient: after preparing the way for him, he leads him on towards the final healing. This 'therapeutic path' is composed of the central healing metaphor of 'inversion' and the specific ritual metaphors we have examined in Chapter Six, all acting together in the framework of a structure of symbolic correspondences which we have outlined.

Besides this, there is another essential element in this process: kworia, the healing power of the mugao. This is part of a larger cosmological view that considers inya, power, as the dynamic energy any Tharaka person shares into some degree: but only the mugao, thanks to his specialist knowledge, can tap and manipulate it at will. It is this communitary-wide belief that, according to the interpretative hypothesis I have put forward, allows the illness metaphors to be comunicated through the patient's subconscious and heal. The inextricable therapeutic triangle of patient, mugao and community is thus the source and the condition of any 'therapeutic effectiveness'.

The last element in this cognitive structure is the myth of origin of Ugao. This represents, as we shall see in Chapter Ten,

the ideological legitimation of the mugao's power. Since this power is fundamentally ambivalent,it gives rise to the ambivalent attitude of the public towards it and those who are holding it. The potential conflict this can produce between the mugao and the community are illustrated by what the myth says: to the extent that the mugao will use his power for the benefit of the community 'selling' it in exchange for goods, this power is legitimized by the community itself. Thus the myth creates a jurisdiction within which such power can be exercised. And the nature of such a jurisdiction, what distinguishes it from other kinds of jurisdiction, is the possibility of 'selling' this power or, rather, 'selling' its beneficial effects in countering human misfortune and sickness. Is it possible to call this a 'professional' jurisdiction? If we define 'professions' as 'exclusive occupational groups applying somewhat abstract knowledge to particular cases' (Abbot,1988:8), I think that the Tharaka mugao fully satisfies this conditions (10). The exclusive character of this occupational group is stressed by the secret surrounding it and the initiation oath it is necessary to undergo in order to enter it. The application of 'somewhat abstract knowledge to particular cases' implies a specialized skill requiring an extensive training and that, not being applied in a purely routine fashion but requiring revised application case by case, becomes 'expertise'. This is what really distinguishes a 'profession' from a 'craft': the practical skill is not a pure technique per se, but grows out of an abstract system of knowledge that generates it. This characteristic of 'applied abstraction' is probably the real peculiarity of

professional expertise; it also marks the difference between it and purely intellectual work.

I certainly believe that the cognitive structure of the Ugao jurisdiction we have outlined points to the existence of an abstract corpus of knowledge based on a system of classification (kuringia), a system of treatment (kurogora) and a cosmological view of the power (kworia). This systematic knowledge is acquired by the mugao through a more or less long period of apprenticeship during which he also acquires the skill to translate this knowledge into practice case by case. The horns (ngoci) are somehow the symbol of this professional art: they contain the knowledge only the mugao can apply by a specialized tecnique. And, by doing so, he repeats the ancient gesture of continuously recreating his professional jurisdiction in Tharaka society.

7.3 'Medical' Knowledge and Professional Jurisdiction

The last issues I wish to deal with are related to the relationship between the professional jurisdiction of Ugao and the 'medical' knowledge it contains: in fact, once we have assessed the existence, the nature and the structure of such a jurisdiction, how can we consider the abstract corpus of knowledge on which it is based? What type of knowledge is embedded within the systems of classification and treatment of human problems, and the cosmological view of power that structure such a jurisdiction? To what extent can we consider such knowledge as 'medical'?

In order to start answering these questions, we can argue with Hughes that 'professionals profess. They profess to know better than others the nature of certain matters, and to know better than their clients what ails them or their affairs. This is the essence of the professional idea and the professional claim' (1963). I think this is the real point of strength of any profession: namely, its capacity to 'apply' a certain body knowledge to solve the specific cases of the clients. In other words, it is not the type of knowledge in itself that defines a profession, but its ability to utilize it to solve practical problems. This is what constitutes its superiority over lay knowledge. In this respect, this nature of 'applied knowledge for practical purposes' immediately brings us beyond the classical debate of scientific versus non-scientific knowledge. It is a particularly sensitive matter, since it is always raised by physicians when faced with the problem of recognition of traditional medicine: their usual answer is that 'it depends on whether or not such medicine can be tested on a scientific basis to assess its effects'. The misleading point in this answer lies in the orthodox view of the nature of scientific knowledge based on the assumption that what is real is only the objective, physical world, and that this observable material can be understood through empirically-tested hypotheses leading to the discovery of natural laws. In this way, there is no room for any unobservable material such as 'witchcraft', 'spirits' or 'curses', which are typical of the way of knowing of the traditional diviner and healer.

However, a new perspective is steadily challenging this

positivistic approach to reality. Its starting point is to dispute that the difference between science and other forms of knowledge is so radical as was traditionally stated. Polanyi (1946) already questioned any direct relationship between observation and reality: what we usually consider as 'facts' are just the result of the categories of thought we use. This allows us to understand the nature of 'intellectual construction' of any scientific (or non-scientific) knowledge, instead of stressing its character of revelation or discovery (Mulkay,1979). Moreover, the creative process in science implies a certain degree of subjective components - imagination, intuition, connection, creativity - that locates it in a much closer proximity to non-scientific expression, particularly art. But most of this process remains tacit, as implicit knowledge, of which the scientist himself is often unaware, since only the results expressed in the scientific idiom become conscious.

I am fully convinced that what Western thought has termed as 'magical beliefs and practices' are the real challenge which traditional medicine such as the Ugao pose in order to reconsider not only the nature of medicine, but of science and scientific knowledge itself. The belief in non-human or super-human forces and powers, and the practice of manipulating them according to human will and needs, create some fundamental epistemological problems for anybody wishing to analyze the nature of such knowledge. The answer of the orthodox positivist paradigm does not admit reply: this is simply neither science nor knowledge; at best, it can be considered as a 'failed

scientific explanation' (11). Any way of knowledge not based on observable entities is considered unacceptable in this perspective.

However, we can start looking at this problem from a different etic point of view. A view that considers Tharaka emic categories of 'visible/invisible world', of 'apparent/hidden reality' as a new, alternative way of considering the problem at issue. If we agree with Fortes (1976) that health and illness first and foremost are 'lived experiences', we can accept the existence of alternative ways of knowing, not based on the objectivity of empirical evidence but on the subjectivity of personal experience. Such non-empirical modes of developing knowledge are well known to all cultures, such as the Tharaka one, where the distinction of an invisible type of reality requires the skills of a diviner to be scrutinized:

> 'Any culture which admits the use of oracles and divination is committed to a distinction between appearences and reality. The oracle offers a way of reaching behind appearances to another source of knowledge' (Douglas,1979:140).

In the production of knowledge, Tharaka like many other African cultures (12) admit to the use of other means besides the five senses used to obtain objective knowledge: and a divinatory session such as that of Ndeke we described earlier is full of such means to knowledge as revelations, dreams, flashes of intuition. These non-objective modes of explanation allow the mugao to penetrate into the invisible world and understand its hidden reality, bringing at least part of it up to the surface of consciousness.

In this way, Tharaka thought goes beyond the Western

dichotomy of body and mind, scientific and non-scientific to grasp the unity of the person in the duality of visible/invisible reality: a duality which requires, in order to be properly explored, a complementarity of means of knowledge, including both empirical and non-empirical ways. If 'health and illness states are to a large extent subjective experiences which must somehow be translated into objective knowledge to be used as the basis for treatment' (Pearce,1986:244), then this needs the acceptance of both subjective and objective forms of knowledge at least on an equal level of dignity. This need not be all. Tharaka indee go further, considering subjective ways of knowledge as superior to objective, empirical ways. On this ground, the construction of the Ugao jurisdiction is founded. Whereas the empirical knowledge based on five senses is available to everybody, subjective knowledge is reserved to a few, skilled individuals. It requires a proper, formal training to be learned: and an halo of secrecy protects it from profane eyes. This creates a tradition of esoteric knowledge that is distinct from the exoteric. Nonetheless, as we have seen, besides his subjective knowledge the mugao also possesses empirical knowledge: an entire day of my apprenticeship was dedicated to learning the treatment of illnesses 'without horns' (4.6). But this empirical knowledge developed through trial and error over the generations is shared, at least partially, by the agao with ordinary people: as M'Mburuki puts it, 'some of these herbs are known by common people, only they do not know them properly' (4.6).

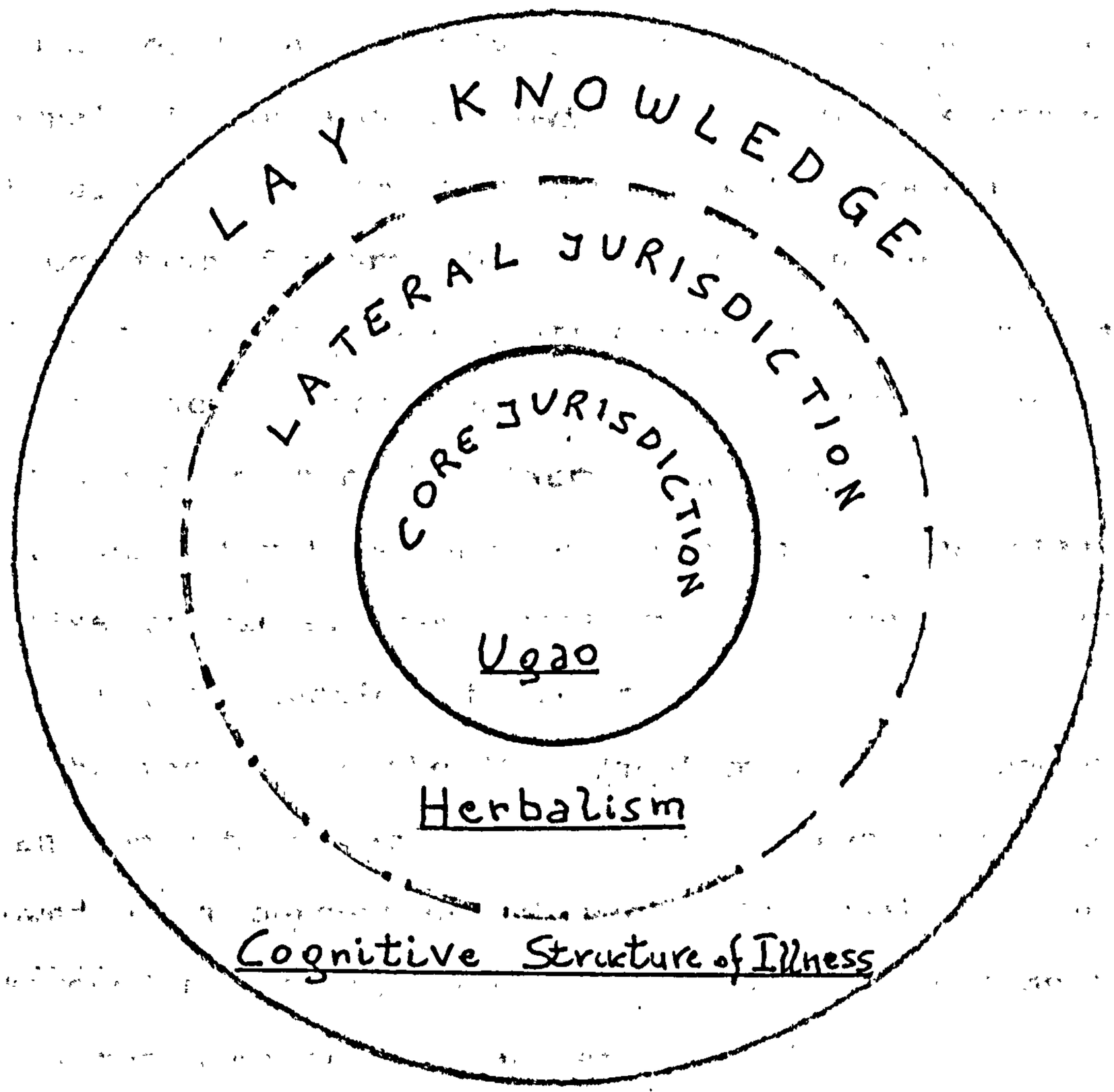
This allows us to infer that, even though empirical materia

medica based on herbal knowledge is fully recognized and present in Tharaka Ugao, it does not represent the core of its jurisdiction. This is instead deemed to be constituted by the horns and the subjective knowledge they contain. This suggests to us the probable existence, in a jurisdiction, of a central area of knowledge under its exclusive control - what we could term a 'core jurisdiction' - and a peripheral area whose knowledge is partially shared with profane, lay people - what we could define as a 'lateral jurisdiction'. In this way, we can identify in a cultural domain (13) such as the Tharaka 'medical' one three different levels (fig.7.2): a core jurisdiction including the exclusive professional knowledge of Ugao, a lateral jurisdiction regarding herbalism which is partially shared by the agao with common people, and a lay knowledge which common people use to cope with sickness (the cognitive structure of illness we analyzed in 3.4). Such a structure defines Tharaka medical domain as a 'mixed' one in Spradley's terms (1980:90).

If this is the structure of Tharaka traditional medical domain, we can understand that its 'medical' nature, as a category of cultural meaning, is quite different from the Western biomedical model. In fact, health and illness are not reduced to essentially mechanical, organismic states that can be considered separately from a person's psychological condition and his social milieu as in the biomedical paradigm (Kleinman, 1978b). Conversely, we could define it as based on a 'psychosocial paradigm' (Good, 1987:14) which conceives the person as an indivisible whole within the two dimensions of the physical and non-physical universe, treated as complementary and integrated.

This allows for both empirical and non-empirical ways of knowledge, where the first is considered available to anybody at the popular level, whilst the second is under the exclusive control of the Ugao jurisdiction. This is because it requires intuitive, para-normal, revelatory powers that only

Fig.7.2 Tharaka 'Medical' Domain



particularly skilled individuals with a formal training can possess and manipulate.

I have tried to explore the cognitive nature of these two dimensions by examining first the cognitive structure of illness Tharaka people use to define and cope with their problems and then the semantic structure of the Ugao jurisdiction. I wish to conclude by stressing the processual, changing nature of these structures. Both are, in fact, highly adaptable and flexible according to the external milieu: as we have seen, nowadays Tharaka people are highly pragmatic in the way they react to external circumstances, showing a considerable degree of intra-cultural variation in their health-seeking behaviour according to non-cognitive factors. But the same can be said of the Ugao jurisdiction: its semantic structure should not be hypostatized into a fixed abstraction. Allan Young (1981) suggests a 'processual' rather than 'structural' view of medical knowledge (14): but 'structure' and 'process' cannot be seen as opposed entities or views. They necessary complement each other in the continuing re-creation of culture.

The insight in the 'Old Ugao' by which I concluded my trip as an apprentice was a particularly meaningful experience: it allowed me a perception of a changing reality seen up on the background of an unchanged one, where fundamental meanings remain the same beyond appearances in the observable world. The material symbols the old mugao Ngunku uses are partially different from those I was taught by my masters; his behaviour and speech did not correspond to the present-day Ugao. My feeling was like a diver plunged into the past of the pre-

colonial Ugao. However, it was extremely clear to my mind that the meaning of what Ngunku was doing exactly corresponded to the system of symbols I had been taught by my masters. Obviously, I do not have all the evidence to support this idea, and this is the reason why I have presented it just as a feeling. Probably, even this is part of the intuitive, subjective way of knowing I have tried to describe.

However, if the past of the Ugao is practically impossible to reconstruct, its future is another matter: my field work experience has allowed me to document in full detail the circumstances that show how the agao has reacted to a different mode of cultural contact, how they have started to transform their material and non-material (both verbal and behavioural) culture to cope with new exogenous cultural elements. It is this changing world of the Ugao we now need to examine in order to understand the processual aspects of the Ugao jurisdiction.

FOOTNOTES TO CHAPTER 7

1) In his well-known description of the way the Cuna shaman carries out his 'journey', with his protective spirits, along the 'path of Muu' in order to help the woman overcome her difficult childbirth (Levi-Strauss,1958:181-201), the ritual performed, and particularly the chant the shaman sings, is, according to Levi-Strauss, a sort of 'symbolic reading' of the patient's condition, a 'language' in which to translate an initially purely emotional situation affecting its resolution. In a condition of psycho-physical disorder, the patient's mind becomes more receptive to a symbolic than to a rational logic, thus allowing the translation of the symbolic effectiveness of the myth into therapeutic efficacy. The cathartic value of the Cuna shaman's chant precisely lies in this process of'abreaction'and transference at work in the ritual: the Cuna woman in labour, like the psychopath, lives again the initial situation that gave rise to the disturbances that caused her problem; and, with the shaman's assistance (like that of a psychotherapist), she can express it, make it clearer, and bring to a resolution. Levi-Strauss locates this abreactive potential of the Cuna shaman's performance in the parallel, contained in the chant, between the spirit journey and the physiology of his patient. From this association, he concludes that 'the song constitutes a psychological manipulation of the sick organ and it is precisely from this manipulation that a cure is expected' (Levi-Strauss,1958:187).
A fundamental role, in this process, is played by the unconscious, which Levi-Strauss describes in terms of an 'empty form' articulating the different levels of meaning, an organ where the specifically human symbolic function is located, working with the same rules in every culture. This sort of reification of the symbolic function in the unconscious is justified for the French scholar by the possible existence of a 'corrispondence' between formally homologous structures such as organic processes, the unconscious mind and rational thought. The effectiveness of symbols exactly lies in this 'inductive property' by which such homologous structures are related to one another and could reciprocally exert an influence.

2) Analyzing the mabolong ritual of the Wana people in Indonesia (Atkinson,1987), the author puts forward a series of critical remarks regarding Levi-Strauss's theory. Firstly, she points out that '... Wana shamans'mabolong chants do not offer a parallel between the geography of the shaman's journey and the distressed anatomy of the patient' (Atkinson,1987:387). The absence of any parallelism is considered consistent with the fact that 'Wana patients have no active role in the ritual nor are signs of psychic or physical transformation expected from them.(...) The significant transformation of self in the mabolong involve not patients, but shamans, and have implications apart from healing' (ibidem). This

conclusion brings the author to reconsider the issue of catharsis in the light of Scheff's approach on emotional 'distancing' as a critical element to the cathartic process. According to Scheff (1977; 1979), to achieve catharsis a dramatic performance must be at one and at the same time 'distressful' and 'vicarious', a balance he refers to as 'distancing'. This is because if distressing, but not distanced, a ritual leaves participants injured to their own pain; on the other hand, if too distanced, the participants fail to make any connection between the performance and their personal experience. This does not mean, as Scheff implies, that the only rituals worthy of the name are those that lead to emotional discharge.
On this basis, contrary to what Levi-Strauss suggested, 'In order to achieve its emotional effect, a ritual must maintain an ''aesthetic distance''. If its performance seems too real, a ritual denies its participants the emotional space to react' (Atkinson,cit:352). This process of 'distancing' would allow the observers to make a connection between the ritual performance and their personal experience without being injured in their own distress: this is achieved by switching attention from the condition of the patient being treated to the shaman's condition producing the catharsis.
On the basis of the complexity of facets of the mabolong ritual, the author finally questions Levi-Strauss's concept of ritual efficacy as being limited to its medical aspects: in fact, the ritual provides a public arena for performers to establish and maintain their reputations as shamans in Wana society. According to Atkinson (1987:346), 'a dominant feature of ritual action involves shamans negotiating with hidden powers on behalf of their community': as a mediator between the spirits and the human community, the shaman produces a cathartic process by switching attention from patient's 'overwhelming subordination' to his own condition. But he does so incidentally, not as a primary end in itself, but rather as part of a 'multifaceted appeal to general audience' (bid.:353). In a shamanistic culture positing the interconnectedness of person, community, and cosmos, the ritual simultaneously addresses patients and a wider audience serving political ends as well. According to the Atkinson, the ritual's therapeutic potential for patients can in fact be properly grasped only after understanding its function of public demonstration to reaffirm the shaman's powers. Once that is done, symbolic healing can be explained in terms of the cultural notion of efficacy: something Levi-Strauss completely ignored in the case of Cuna shaman, presuming that the dynamics of healing he outlined took place apart from actors'emic explanations. But, how can he attribute the therapeutic efficacy to the symbolic correspondences between the words of the song and the patient's anatomy if, as Sherzer indicates (1983:134), the Cuna shaman's chant is not even comprehensible to the patient? According to the Atkinson, 'efficacy ... lies not in the public side of the shaman's performance , but rather in the shaman's secret knowledge and personal association

with spirit familiars' (Atkinson,cit:344). What is really efficacious are not the shaman's words and gestures in themselves: they just express and refer to the shaman's hidden powers, while concealing them at the same time. It is in this exoteric knowledge and the spirit ties it implies that the real source of the shaman's effective powers lies.In this way, the 'effectiveness' of the ritual lies in shamans themselves (as the title of the article points out) and not in the symbols as such.

3) The author (Moerman,1979) takes a wider approach to the problem of healing trying to explore the underlying physiological and cognitive mechanisms involved in it. In doing so, he challenges the validity of the mind/body duality which has been dominating Western thought for centuries, and still is. However, as most of the comments following the pubblication of Moerman's seminal article show (Current Anthropology, vol.20,n.1,1979:66-75), criticism of mind/body dualism in his approach still lacks a clearly formulated conceptual frame and appears too weak, and poor in its organization of materials. His departure point is a useful distinction among three different types of medical treatment, considered as an adaptive reaction of an organism to its environment: general, specific and autonomous medical treatment. The former is based on the 'widespread, perhaps universal idea... that one person can heal another' (Moerman,1979:59). This 'helping relationship with a therapist... along with other related, nonspecific effects such as suggestion and abreaction' (ibidem) constitutes the way by which the healer mediates between nature and culture: thus enacting 'cultural physiology'. Specific treatment is based on the notion that 'specific diseases require specific medical treatment' (ibidem); and it is central to the practice of biomedicine. Autonomous medical treatment, finally, comprises 'all internal biochemical responses to disease or injury, such as immunological or inflammatory response' (ibidem).
In order to analyze the mechanisms underlying general medical treatment, Moerman relies on recent research findings in psychosomatic medicine, biofeedback and host-pathogen interaction. He provides us with a useful brief review of current thinking and results in psychosomatic illness, bio-feedback and host-pathogen interaction. Particularly, 'psychosomatic research has demonstrated the potentially pathological relationship between mental and physical events' (Moerman,1979:61) and the therapist can influence this pathological pathway by reversing the signs, the valences, the external forces causing harm, and thereby healing. Bio-feedback research 'illustrates the broad range of physical events that can be controlled by conscious mental activity': subjects can influence heart rate, blood pressure, core body temperature, salivation, urine formation, etc.. A related line of research has focused on the ability of several sorts of typically Eastern mystics to control basic physiological processes by

specific techniques. Finally, 'recent research on immunological processes indicates that disease is as much a function of host reactivity as it is a consequence of invasion or infection' (ibid.).
By placing the above findings in an anthropological framework, Moerman indicates the existence of substantial pathways linking physiological and cognitive states together. This metaphorical structure, this system of meaning, is the underlying mechanism affecting therapeutic effectiveness in the context of a unitarian mind/body organism model. In this respect, Moerman questions what he regards as an 'inappropriate conceptualization' of the problem of efficacy in terms of mind/body dichotomy, such as: 'how can symptoms affect physiology ?'. Recent research in neuroendocrinology suggests that 'the hypothalamus is the key to a neurophysiological model for a nonsegmented conceptualization of the human organism, since it operates as both a neural and an endocrine organ, thereby urging us to drop the separation of 'mental' and 'bodily' processes' (cit.:65). Although his non-Cartesian, holistic approach still appears too weak, especially in its conceptual frame, Moerman's hypothesis on the power of meaning, the significance of symbols, based on 'metaphorical structures' that lead us to performance, changing our behaviour, is intriguing. Most of the psychotherapeutic literature recognizes, in fact, forms of unconscious or out-of-awareness communication and meanings rooted in personal and cultural contexts. I believe that this problem involves complex epistemological and ontological issues we cannot deal with here; however,there is certainly a need for a significant study of the problem in relation to culturally determined healing systems, with special reference to the modes of communication involved.

4) From the patient's viewpoint, this discrepant practitioner's assessment may cause them to leave treatment or fail to comply; but most of them seem to accept this different view 'as part of the medical mystique,the medical expert's special understanding of the problem and its treatment' (cit:22). Successful treatment, indeed, is for the practitioner the consequence of proper ritual treatment, whether there is symptoms relief or not. This is the way the shaman may claim partial or even complete cure in spite of the absence of any symptom change:'Practitioners of shamanistic and other temple-based healing in Taiwan are usually quite clever at explaining therapeutic failure in such a way as not to imply that their god's healing powers have been inadequate'(cit:21). The point is that, for most practitioners, treatment is directed at both of the two aspects, <u>disease</u> - meaning any primary malfunctioning in biological processes - and <u>illness</u> - defined as the secondary psychosocial and cultural responses to disease. This well-known distinction has become a key axiom in Medical Anthropology: it is worthwhile to note here that 'disease' and 'illness' must be considered as explanatory concepts,not as 'real' entities. Engelhardt(1974) views them as representing relationships, as constructs in

particular configurations of social reality, to be understood only within a defined context of meaning and social relationship. Or, as Kleinman puts it (1980:73), 'disease/ illness can be thought of as expressing different interpretations of a single clinical reality, or representing different aspects of a plural clinical reality, or creating different clinical realities'. From the patient's viewpoint, the two perspectives are often not distinguished; but what is really important, here, is that cure alone is not enough. Patients 'require explanations of their health problems that are personally and socially meaningful, and that usually require the practitioner to explain about the disease as well as the illness' cit.:22). The traditional forms of healing include both these two closely interrelated functions: providing effective control of the sickness and personal and social meaning for the individual experience of being ill in a certain cultural setting.Modern biomedicine instead attends solely to the former. Finally, from the viewpoint of the researcher, the problem of healing and its evaluation is more complex; as the authors put it, 'For the researcher, this is a special problem. Which definition does he use for disease (indigenous or biomedical), which for illness, and when he evaluates cure is it cure of the disease (and which view of the disease) or the illness, or both?' (cit:22). Evaluation of healing involves all these issues, which shows how healing cannot be assessed in the abstract,but only within the social and cultural context in which it is anchored - to the extent that, paradoxically, traditional health care systems can heal even if they are unable to effectively treat the disease. This was true of the patients who, according to Kleinman and Sung, when they were examined,were 'culturally' healed by the construction of clinical reality provided by their social context. In conclusion, indigenous practitioners successfully heal because they cure illness, not disease; and, by doing so, they provide psychosocial meaning for the disease itself and clinical resolution for the personal and social problems which comprise the illness as a human experience.

5) It appears particularly meaningful that the same kitharaka word 'inya' is used for the number four.

6) Within the two worlds, there is a further subdivision among seven levels of existence: Murungu (God), nkoma cja bajuju (ancestors), nkoma (spirits) in the invisible world; muntu (man), nyamo (animal), muti (plant), and gintu (inanimates things) in the visible world. This ontological view of the universe is common to other African peoples (Mbiti,1969:16). I want to thank my field assistance Januarius M.Riungu for his helpful assistance on this point.

7) According to Tharaka thought, there is power in nature: certain animals and plants are believed to possess native power which can be used by arogi to injure others or by agao to restore health. There are poisonous plants whose esoteric knowledge is used to prepare deadly poisons

together with poisonous animals such as snakes, frogs, chameleons, spiders and scorpions. Conversely, animal fats are used to heal and to protect against urogi: maguta ja ngurwe (pig oil)is used for measles, coughs and urogi; maguta ja njogo (elephant oil) is used for ear ache and urogi; maguta ja ng'ondu (sheep oil) is used for snake bites,coughs, mouth sores in children and urogi.

8) For Tempels (1959) the key concept in African philosophy is what he calls the 'vital force': this represents the essence of being and the ontology that permeates all aspects of Bantu societies. Since it is primarily the result of his personal interpretation of Baluba thought (among whom he he had worked for many years), it sounds ambitious and hazardous to generalize it as 'Bantu philosophy'. The concept of 'mana' is originally a Melanesian term used in opposition to 'mara': the first is power, success, luck, whereas the second is weakness, unsuccess, misfortune (Codrington,1891). The term has become famous because of the interpretation proposed by Marcell Mauss in his essay on the general theory of magic (1950).

9) The psychotherapeutic literature which has 'most focused on the issue of meaning in relation to behavioural change recognizes unconscious or out-of-awareness communication and meanings rooted in personal history as well as current context. It is that of psychoanalysis beginning with the works of Sigmund Freud' (Brody, E., Comment to Moerman's article, 1979:68).

10) Freidson's definition of profession is more sociological: 'an occupation which has assumed a dominant position in a division of labour, so that it gains control over the determination of the substance of its own work' (1970a:15).

11) As Devisch (1985) has pointed out, a dominant perspective in anthropological studies of divination has been an intellectualist one in which divination has been characterized as 'failed scientific explanation': the classic work of this approach is Evans-Pritchard's study of Zande magic (1937), which he considers as logically consistent even though it is based upon false premises.

12) Among the others, the Yoruba of south-western Nigeria, as was well pointed out by the interesting essay of Tola Pearce (1986).

13) According to Spradley, a 'cultural domain is a category of cultural meaning that includes other smaller categories' (1980:88). Then he describes three kinds of domains, according to the type of language used: 'folk domains', 'mixed domains' and 'analytic domains'.

14) Young argues that structural views of medical knowledge either bracket out important emotional and ideological

determinants or trivialize them. He concludes that, given the recursive and processual nature of the creation of medical knowledge, a processual approach is better suited to understand the different ways the social actor produces knowledge.

Plate 7. Swearing on the goat: Kithino group during the giciaro ceremony (September 1985).

Plate 8. Kithino group in front of its gaaru (June 1987).

Plate 9. During a meeting between the CUAMM doctors and the agao of Kamanyaki group (April 1986).

Plate 10. Chiakariga: Chief Benson delivers the certificates issued by the Ministry of Health (June 1987).

PART III

THE CHANGING WORLD OF THE 'AGAO'

CH.8 THE SELF-DEVELOPMENT PROCESS OF THE 'AGAO'

8.1 Social Change and Role Adaptation of the 'Agao'

By pointing to the existence of an Ugao jurisdiction at the core of the 'cognitive structure of illness' which Tharaka people use to orient their health-seeking behaviour, we have been able to single out the internal semantic structure of the jurisdiction itself by examining the concepts and work of Ugao through data derived from my direct apprenticeship as a mugao. 'Kuringia', 'kurogora' and 'kworia' provide the cultural, cognitive machinery of the Ugao jurisdiction by means of which certain human problems are dealt with in a culturally acceptable fashion. However, this is not enough: as Abbott puts it,

> 'But to perform skilled acts and justify them cognitively is not yet to hold jurisdiction. In claiming jurisdiction, a profession asks society to recognize its cognitive structure through exclusive rights; jurisdiction has not only a culture, but also a social structure'(Abbott, 1988:59).

This 'social structure' probably includes certain claimed rights and corresponding duties, possibly some powers, privileges, liabilities and immunities: in other words, all the attributes of a social position that define a 'status' and a 'role'. Consequently, a jurisdiction creates a social identity (1), that of the professional, which needs to be examined in the context of the surrounding set of social relationships. We have already discussed this problem within the more general social division of labour, from an historical point of view, in Chapter Two: here, and in the following chapters, I shall try to look at the problem

in more dynamic and operational terms.

In the past, there have been some anthropological attempts to rethink the concepts of 'role' and 'status' in order to build models for more general analysis (2): they have started to approximate what Goodenough termed 'the cultural organization of social relationship' (1965). In particular, some studies have tried to examine the 'healing role' within the context of social change resulting either from cultural contact with Western culture or from internal innovation. One of the most interesting is certainly that of Landy (1977:468-481), proposing the concept of 'role adaptation' as a key to understanding the response of curing roles under the impact of acculturation and social change in selected societies. The concept of 'role adaptation' by Landy represents an extension of the theory of 'role strain' (3) proposed by the sociologist William Goode (1960). In fact, whereas earlier examinations of responses to role change were mainly in terms of conflict as inevitably arising from cultural contact, Landy stresses the possibilities for role adaptation by indigenous curers insofar they are able to adopt some of the theoretical and behavioural elements of the impinging culture in order to enhance their therapeutic efficacy and even strengthen their social status in their own societies. This process of cultural borrowing from Western medicine represents the basis of a more general process of role adaptation, defined as 'the process of attaining an operational socio-psychological steady-state by the occupant of a status or status set through sequences of "role bargains" or transactions among alternative role behaviours' (4).

On these premises, Landy founds a typology of role adaptation possibilities in terms of three categories: 'adapting', 'attenuated' and 'emergent' curing roles. The first category groups those cases of successful response to the demands of acculturation, either by creating a sort of 'division of labour' ('folk medicine' and 'doctor medicine'), or by incorporating some technical or ideological elements from Western medicine and Christian religion, and then resynthesizes them in new syncretic forms. Attenuated curing roles are represented by those cases in which the curer may choose to continue in his traditional way, ignoring the presence of biomedical services and their probable effects (e.g., declining clientele). This implies a voluntary acceptance of diminished prestige by the healer and a basically conservative attitude towards social change. Finally, the contact situation may stimulate new, emergent roles, especially in those societies in which, at least apparently, there had been no traditional curing roles (such as the Manus of New Guinea studied by Mead:1930). In these technologically simple societies, the impact of Western culture and medicine gives rise to new syncretic curing roles (5).

This successful instance of syncretic cultural creativity brings this figure near to the notion of the 'cultural broker'(6), and its mediating functions between two worlds in contact. As Press suggests (1969), the strength of this role lies in its incorporating a large number of mutually dependent roles from both cultures, rendering the total configuration of this role-set all the more ambiguous. This in turn seems

to suggest a revision of the well-established general principle of social change which states that those practices, ideas and roles which are more consonant with the host culture will be more easily transferred (7).

Returning to the matter of ambiguity in the cultural broker role, we can argue as does Landy that, insofar as the indigenous healer incorporates and resynthesizes elements from Western medicine and culture, 'he increases the ambiguity of his role but also the possibility of his adaptation to the acculturation situation' (cit:480). By increasing what is already fundamentally ambiguous in his traditional role, the healer has a chance to play the role of cultural broker innovatively. This will be furtherly facilitated by the fact that his work is associated with phenomena of great uncertainty and unpredictability (life, death, illness) which make his powers of controlling the uncontrollable forces behind them even more needed. Consequently his role, which stands at the intersection of religion, magic and psycho-social therapy, will fit within the interstices of biomedicine with great success:

> 'As the course of disease becomes more controllable (prevention, public health measures), more predictable (medical intervention with miracle drugs, scientific surgery) and less uncertain, the curer's role faces its greatest challenge. Its survival, of course, is heavily dependent in the acculturation situation on the ability of its incumbents to increment their power through adoption of what might, in indigenous terms, seems to be western ''magic''. But he soons learns that most serious diseases may still be essentially unpredictable and uncontrollable, and in this basic uncertainty lies the probability of successful role adaptation. For he should come to know that uncertainty is often no less for his scientific competitors than for himself' (Landy,cit:480).

After showing the merits of Landy's approach to the analysis

of the traditional curer's role under the impact of acculturation, I wish to conclude my discussion by putting forward some criticisms. The first criticism is related to his concept of role: in my opinion it is not adequately defined and articulated. The status-role concepts have been discussed at length, among others, by Linton (1936:113-114), Merton (1957:368-70) and Goodenough (1965): I personally agree with the position of Nadel, who separated the two concepts. He defined the role as 'basically a type or class concept' that 'labels and brings together numbers of individuals - human beings in our case - in virtue of certain properties they have in common' (Nadel,1957:22). On the other hand, he uses the term 'status' in a narrow sense as referring to the 'particular sets of rights and obligations falling to persons' (cit:29). In my opinion, the 'common properties' shared by individuals filling the same role considered as a class concept, can be defined in terms of social functions: that is, in terms of a series of activities and tasks performed in the social structure (8). On the other hand, the status 'sets of rights and obligations' can include, in my opinion, the social rewards pertaining to it, both of material (economical) and immaterial (prestige, power, influence, etc.) nature (9).

With this distinction in mind, we can go back to Landy's model to check its utility. In fact, if we try to apply it to the curer's case, we can revisit Landy's concept of 'role adaptation' by using it in a narrower and less psychological sense (which remains, in any case, a necessary, but not the principal, component). The concept could be used to define any successful

case of the curer's role adjustment to social change in terms of series of social functions, activities and tasks performed. In my Tharaka case, for example, this means singling out the reduction of social functions (and related clusters of activities and tasks) performed by the mugao's role with respect to the past. In fact, the mugao once played an important social function during those important components of the social structure and individual lives that were the initiation rituals, such as circumcision. During both the female and male ntano (circumcision) ceremony, a mugao was called in the evening of the day preceding the proper initiation to perform 'kwoga mucii', a sort of purification ritual of the candidate's home to remove any impurity and evil. The same ceremony was repeated ten days after the initiation (Volpini, 1978:100-3). The fact that the kwoga mucii is no longer performed seems to indicate the current disappearance of this important 'public' function of the mugao and an emphasis on other, more 'private', curing functions. Another important traditional function was that of social control: in particular, through the purposeful usage of urogi, the mugao acted as a means of controlling people's materialist appetites in a fundamentally egalitarian society. Besides, through rituals such as kibitana, mugiro, or kirumi he acted as an agent of moral control over any behaviour considered as socially immoral or deviant. Both these two functions have relatively diminished in a society where religious and legal functions have become socially differentiated and social stratification is steadily increasing. The result of all these

processes seems to be a substantial 'privatization' and 'medicalization' of the social functions exercised by the profession of healer in Tharaka nowadays: and this is probably the type of 'role adaptation' chosen by the agao under the pressure of acculturation. What cognitive adjustments this has required in order to mantain their professional jurisdiction would be an interesting issue but one we are unable to tackle here.

With regard to the 'status' concept, if we try to apply it (in the sense we have previously defined) to Tharaka agao, we can discover a perhaps unusual differentiation. In fact, not all the agao I met enjoyed the same social status in terms of material and non-material rewards. On the basis of my research findings, I suggest we can subdivide the current situation of Tharaka agao in terms of social status into three main sub-groups:

1) the marginal: mainly those oldest agao with a very small clientele or who are no longer active at all, and having a very modest economic situation;
2) the local: those agao whose professional activity is limited to the local level and still largely performed in a traditional fashion, with a relatively good socio-economic status within their community;
3) the well-known: the most famous agao with a large,nation-wide clientele, performing their work in a more acculturated fashion and having considerable wealth.

In Landy's terms, we could consider the first group (who are few in number) of marginal agao as being in an 'attenuated' curing role; the second group (the majority) of local agao as

'adaptive'; and the third group (very few) of well-known agao, who are able to subsume new cultural elements as 'emergent'. But in this case, we should add that all the three role-categories can be present in the same society at the same moment with regard to a single identical curing role; and that this status situation, although certainly related, should be considered independently from the role situation. The processes of role transformation we described have, in fact, affected all the three status groups; and their different present situation can be read in terms of more or less successful 'role adaptation' under the impact of acculturation.

The second criticism I wish to raise regarding Landy's approach is related to the other pole of his causal chain: the cultural contact (independent variable), whose impact on curer's role (dependent variable) produces social and cultural change (effect). The acculturation process is considered by Landy in undifferentiated terms: there is, in fact, no distinction among different possible kinds of cultural contacts and the substantially different results they can produce. I will follow Roger Bastide's distinction (1971) between at least three different types of acculturative processes: 1)'free' contacts, 2) 'forced' contacts and, 3)'planned' contacts. In the first case, the cultural forces are left to act freely according to the rules of cultural determinism (10); in the second, they are directed in the exclusive interest of a certain class or group (colonial or slave rule) with pathological and destructive effects due to ignorance of cultural determinism; the last

is based on the belief that cultural determinism (once known) can be directed and controlled in the interest of the local community. Therefore, the key rule of this third type of cultural contact is that it is possible to 'orientate' the resulting process of social change towards a direction that is respectful of the traditional values, norms and beliefs (in other words, of the culture) of the community itself. In this case, an 'oriented change' will be the result of a process of 'planned acculturation', of 'development in the tradition' that foresees and takes into account the effects (social, psychological, economical, etc.) of any new cultural element introduced. The basic assumption of this approach is that every culture is not static but dynamic, based on its own internal 'cultural trend' (11). This endogenous dynamism will interact with any exogenous dynamism introduced, interposing its own rhythm and direction of change to any awkward and hasty attempt of 'externally-directed change'.

Returning to our criticisms of the concept of 'role adaptation' as formulated by Landy, I believe that the heuristic value of such concept will be greatly enhanced if used in a more limited way (by distinguishing it from status, the complementary concept), and critically applied as a model describing the possible result of different kinds of cultural processes.

8.2 Groups Formation by 'Giciaro'

In Part II we have investigated the indigenous professional culture (the jurisdiction of Ugao) as the necessary preliminary step, at the cognitive level, to any real self-development process; but this is not enough. As we have seen, a jurisdiction produces a professional role at the social level: what happens to this role when this process of 'oriented change' is pursued through a 'planned cultural contact' such as in the action-intervention level of PAR approach of the Tharaka Project? The role, just like the jurisdiction (Cf. old/new Ugao in 7.4), is not static: the concept of 'role adaptation' we have formerly discussed can then be a useful tool to analyze its internal dynamisms. But is it enough? Or do we need another conceptual tool to critically examine what changes this role undergoes in a situation of controlled acculturation? In order to answer this question, we first need to analyze one by one the changes introduced: then we shall be able to look at them in a more comprehensive way.

The first change arises from the different nature of the two agents of the cultural contact: on one side we have an organized, well-structured subject (biomedical personnel and health care facilities) while, on the other side, we have a dispersed, unorganized subject (traditional health practitioners). Certainly, a possible solution to this problem could have been the selection and, eventually, the incorporation of individual practitioners (probably those I classified as 'well-known'): but this was excluded in the CUAMM Project,

since it would have meant more an individual status advancement (12) than a collective self-development process. This brings us to singling out the preliminary condition of any process of planned acculturation: the two interlocutors should be on equal terms in order to achieve a mutual dialogue.

The nature of the mugao role is traditionally individualistic and competitive in Tharaka (13): each mugao works alone, sometimes with a young apprentice carrying his kiondo. Such individualism stems from two conditions, one endogenous and one exogenous to Tharaka culture. The first, endogenous condition lies in the ambivalence of the Ugao's power which can be used for either good or evil purposes. This creates a feeling of reciprocal fear and mistrust among those who practise it: with the consequence that everyone wants to show the superiority of his power over that of others, even in order to achieve greater rewards. As one of the most famous old agao, Muthoro Kiburi (whose portrait, painted by Joy Adamson in the 1920s during a trip to Chiakariga, is in the National Museum in Nairobi) once told me, 'We have no cooperation with the other agao: we are indifferent to one another. Two lions in the same forest fight among themselves. We fight for payments. I work alone, except Kijuru who assists me' (Int.2.a.1,p.2). The second, exogenous condition of such individualistic attitude by the agao is due to their semi-illegal state,which has lasted since the Witchcraft Ordinance in 1925. Even though the Ordinance is rarely applied,it has created an attitude of fear of prosecution among the agao who are still scared of working in the open.

In spite of these constraints, it is interesting to note

that, when faced with the possibility of a new relationship with biomedical personnel, none of the agao I interviewed (forty-five; Cf. Appendix A) replied negatively. Only the few old agao I classified as 'marginal' did not show a real interest, but this was just because their general professional situation was substantially declining. All the others showed a great interest in the proposal of changing the traditional lack of any relationship with modern medicine. Possibly, the 'local' healers looked at it as a chance to enlarge the range of their audience, while the 'well known' healers saw it as an opportunity to further increase their fame. Apart from any difference in individual motivation, what it matters here is the generally shared positive attitude shown by them towards the process of 'controlled contact'. However, the problem they immediately raised was that this would inevitably clash with their traditional way of managing the mugao role. But what was even more striking, was the total, general agreement on the only possible way to overcome this problem: by taking an oath. This would have allowed them to join together in a new form of brotherhood (giciaro) on a professional basis.

To understand this, we should recall the meaning of giciaro in Tharaka social organization (see 1.3): this 'blood brotherhood' represents the traditional way of establishing a friendly and mutually collaborative relationship between different social units (including Meru subtribes). The terminology associated with giciaro relationships is normally the terminology of kinship: this denotes a clear intention by the

participants to create a form of fictive kinship. As we have seen in Chapter One, Lowenthal distinguishes three major types of giciaro, according to the way they are created and the kind of obligations they entail: by kinship, by oath and by goat. However, he admits that his informants were unclear as to exactly how each type of giciaro was formed; and that 'there is no separate term for any of the forms of giciaro in normal discourse, and the only way to differentiate between them is to actually know how they were formed, or to suppose the manner from the obligations entailed' (Lowenthal,1973:42). I did not find any trace of this distinction during my fieldwork; and, unless it is due to the fact that he worked in Tharaka about twenty years before me and in a different area (Gatunga, in North Tharaka), I suspect that his distinction is purely theoretical. He had probably no chance to observe a giciaro being formed: otherwise, he would have realized that all types involve a goat and an oath taken on it. Moreover, according to what I saw, kinship terminology and the sucking of goat's blood are common elements. What seems to distinguish different types of giciaro (there are probably much more than three types) are the varying organizational order of the social units involved, and the mutual obligations which they wish to be included in a giciaro. Since, in fact, giciaro may be created between almost any two (or more, a fact which Lowenthal does not recognize) social units, the content of the 'blood brotherhood' would differ according to whether clans or sub-tribes or individuals are involved. Where clans are involved, there is a strong sibling link which entails exogamic restrictions. When

sub-tribes are involved, military alliance was the main content of such a giciaro. When it was a giciaro between individuals, then mutual aid and such simple obligations as unlimited hospitality were implied. All this created a system of reciprocal obligations, which acted as an informal indigenous law, ensuring the social order by establishing a relationship between two or more social units not otherwise related. This purpose becomes clear if we consider that, in the event of a breach, the oath would have to be sworn again at that time, reinstating the relationship and insuring against a second breach. In case of conflicting obligations, the strongest, prevailing giciaro was the one which involved the greater number of individuals, that is a major organizational entity; the other, weaker types of giciaro however were also taken into account.

Nowadays, the only surviving form seems to be the giciaro between individuals: since the giciaro between clans, as Lowenthal states, 'is no longer being created except as clans segment and this segmentation of clans may have ceased with the introduction of tax records which ''freeze'' clan membership' (ib.:47); furthermore, the giciaro 'involving military alliance is unnecessary today, given governmental control over such matters' (ib.:47-8). The giciaro between individuals is considered as a form of friendship formalized by ritual. In the particular case of the Ugao, this is anything but new: as we have seen in Part II, it is traditionally used between the master and his apprentice to link themselves in mutual cooperation; sometimes, it was also taken between two agao wishing to become

allied and to avoid any conflict between them.

In the case we are dealing with, what we have said about giciaro can explain the reason why all the agao interviewed agreed on the fact that the only way to overcome their traditional individualised practice and fear of each other was to take an oath among themselves: this is the just Tharaka traditional way of establishing the social relationship of mutual cooperation among people. What it appears really new, is the fact that this traditional method is being used to create a new social unit, namely the professional group of agao. This process, as we shall see in the next paragraphs, has at least two strong implications: the creation of a new type of 'organic solidarity' in a society traditionally based on 'mechanical solidarity' (14), and a re-definition of the usual way of working by the mugao himself.

8.3 Swearing on the Goat

In order to fully understand the meaning of the giciaro as a means of group formation among the agao, I shall present an instance of one of the four group oaths I attended in Tharaka. I have chosen the one done by the Kamarandi group because of its particularly genuine and basic features, possibly due to the fact that most of the members of this group are elderly and scarcely influenced by acculturative elements even in the recent past. The description is taken from my field notes (17 June 1986), integrated with the transcription of tape-recorded material.

'As it was previously arranged, the four agao of the Kamarandi group headed by Kienge meet at a quiet place near Mukumbu's homestead, not far from Kamarandi market, for the swearing-in ceremony. The Sub-chief of Kamarandi is also with them, to testify to the lawfulness of what will take place. First of all, they sit in the shade of a big tree to arrange the details of the ritual and discuss some issues. The first problem is the absence of the fifth member of the group, Kajece Mukanda. They do not know the reason for his absence: after a length discussion on whether to take the oath in any case or not, they decide to continue as scheduled. The absent member will take the oath alone, later on. The second issue is related to the presence of the local authority, the Subchief of Kamarandi Paul Nguu: some members suggest that he should also swear together with the agao; others are doubtful. Finally, they decide that the Subchief will swear after all, but with a different wording, just about his loyalty to what he has witnessed.

Then the goat, which was prepared by the agao, is carried in and two of them kill it by suffocation making it face the direction of Kirinyaga (Mt.Kenya). Then one of them cuts the jugular vein to drain all the blood, which is poured into a tin. Using a knife, he then cuts the throat and breaks the lowest part of the right limb of the goat. With the assistance of the other agao forming a circle around him, the mugao is given some objects which he puts into the opened throat of the goat: they are kirika and rurindi (the two sticks traditionally used to make fire by friction), kajiu (a knife), mukua (a big needle), and ithagiro (the goat's broken leg). Finally, he adds some charcoal taken from the fireplace. At this point, the actual swearing-in ceremony can start: the oldest man among the agao and their leader Kienge is the one who will first swear, followed by all the others. Each of them in turn kneels near the goat on the ground and, while holding with the right hand the broken leg of goat and with the left hand all the other objects placed in its cut throat, recites the wording of the oath. In the meanwhile the other agao in a circle continously rub two sticks they keep in their hands, repeating the refrain at the end of each individual oath.

Kienge: 'Elders, the way we found things, we found our grandfathers doing this; and the way we found our grandfathers doing this in the manner of their grandfathers: it is very ancient. It kills someone if he does not follow it: if one has taken this oath and said that "I will never do (something)", and he goes and does that thing, he should be killed. I swear by this oath!'

All: 'Let it kill the one who acts against the truth'.

Kienge: 'Now with this oath, since we are united as agao in one group, please, there is none who can cheat another one, or talk about him outside the group. If one hears gossip outside, he will come and tell the group's member, I swear by this oath!'

All: 'Let it kill the one who does not follow the truth'.

Kienge: 'When I am going around treating people, I do not know anything I could give to someone to harm him. I swear by this oath! Where men have crossed, we all pass there!'

All: 'We all pass there!!'

Mukumbu: 'This oath will stop people from fighting, I swear by this oath. By this oath of our group, I cannot think of looking for something to harm any of my fellow agao, I swear by this oath! Even a fellow Tharaka person or a Government official, I cannot say ''Let me look for something that will harm him''. I swear by this oath! Today we have united as a group of agao. Where men have crossed, we all cross there. I swear by this oath!'

All: 'Let it kill the one who does not follow the truth!'

M'Muriki: 'This oath is the one that joins people and they become children of the same mother, I swear by this oath. This oath we have taken as agao of Kamarandi, even if we eat together at night , I cannot have anything that can harm anyone of this group. I swear by this oath!'

All: 'Let it kill the one who does not follow the truth!'

M'Muriki: 'Even if I go to strange places, and I come to know a secret plan against a group's member by a different person, I would come and tell him, I swear by this oath! Where men have crossed, is where we all cross!'

All: 'Let it kill the one who does not follow the truth!'

Mbobori: 'This oath is taken by those who do not agree. Agao from old days of our forefathers were taking this oath when they could not agree with one another, when they called each other 'murogi'. They were taking this one because it is an old oath, and it is taken by agao. There is no other apart from this (oath) on the goat. I swear by this oath!'

All: 'Let it kill the one who does not follow the oath!'

Mbobori: 'Now this group of our agao, since we have united and taken the oath that is taken when someone has disagreed with the other, even if I hear one of us being talked about by a person somewhere, I would run and tell him what it was happening. I cannot tell a lie. I swear by this oath!
This Ugao is from my father, my father M'Mkwarema Mukuuri showed me, I was not taught by paying somebody.
I cannot say 'Let me wish to harm a ''black'' person, or a ''red'' one, a person with blood, a Kenyan, by giving him something bad. I swear by this oath. Where men have crossed, is where we have all crossed. I swear by this oath!'

All: 'Let it kill the one who does not follow the oath!'

Subchief: 'By this oath of today we have come to unite with our old aqao. I cannot have anything to harm them with, or any other person. Today, as I hold this ithaqiro, I swear for good things because we are coming to cooperate completely. I cannot get something to harm them, I swear by this oath!'

All: 'Where men have crossed, we all cross there!'

Now all the objects used to swear (including the ithaqiro) are taken out of the throat of the goat and each mugao turns them round his head, first clockwise and then anticlockwise; then everybody licks with his tongue the goat's blood remained on the tip of the objects. Even the Subchief does so.

Finally, the goat is skinned with great skill and partially boiled and then eaten on the spot (the liver and the breast); the remaining parts are divided equally among the participants.'

The above description of the swearing-in ceremony contains a series of symbolic elements that I shall analyze by the same approach I used to examine the Ugao rituals. The exegetic and operational dimensions will be particularly emphasized. Since the meaning of the only dominant symbol present (the goat) has been already explained, we shall pass on immediately to analyze the other instrumental symbols. These include the ithaqiro, kirika and rurindi, kajiu, mukua, charcoal, the rubbing sticks, the actions of 'licking the goat's blood' and 'passing the instruments round the head', and the wording of the oath.

Ithaqiro, the broken right limb of the goat, represents, according to Tharaka exegesis, both the breaking of the oath and its consequence, death. Anybody who breaks the oath, will die. The same strong exegetic meaning is reinforced by the other objects put into the cut-open throat of the goat: kirika and rurindi, the two pieces of wood used to make fire, stands

metonymically for the fire that would burn the transgressor; kajiu, the knife, by which he would be stabbed; and mukua, the big needle, representing the starvation that would affect him. It is worth to note that all these symbols are also present in urogi rituals with an analogous meaning.

Charcoal pieces used are an interesting symbol on account of its ambivalence: just as they were produced by fire which has now cooled, so they represent simultaneously peace and conflict. The fact that they are put into the goat's throat together with the other objects seems to further support the idea that, in case of an oath being broken and conflict in the social relationship involved, the transgressor would be seriously punished.

The two small sticks the bystanders continuously rub during the oath-taking are related to the two refrains they repeat:

'Where men have crossed, we all cross there!'
'Let it kill the one who does not follow the truth!'

The first refrain commands loyalty to the agreement established by the oath: this includes to avoid any gossiping (the rubbing sticks) about the other participants. The second refrain emphasizes the consequence for anybody gossiping or lying about other group members.

The proper wording of the oath strongly stresses, with little variation by the participants, the new social relationship being established by the oath using the language of kinship:'This oath is the one that joins people and they become children of the same mother' (oath of M'Muriki). The obligations that arise from this new relationship are mainly proscriptions: not to harm intentionally any of the other group members ('I cannot

think of looking for something to harm any of my fellow agao', oath of Mukumbu). Among the prescriptive obligations, there is the duty to protect the other agao from any gossip: 'If one hears gossip outside, he will come and tell the group member' (oath of Kienge).

Finally, the two actions of 'licking the goat's blood' and 'passing the instruments round the head' seal the agreement stipulated. In particular, it is the goat's blood that, once licked, is believed would materially affect the transgressor. As the participants explained me:

> 'If one does not comply with the oath, he will be affected and die. If one dies because of this oath, he has been killed by his own mouth, because of the words he said: the oath kills because what one swallows will not leave one's stomach. The blood he swallows will kill him because of his saying a lie' (Field Notes, 17/6/1986).

The other action is significantly repeated twice: once clockwise and then anticlockwise. This immediately recalls the meaning of 'making circular movements' in the urogori rituals: anybody who would intentionally bewitch any of the other group members (first movement) will be immediately affected by the oath in the same way (second movement).

On the whole, all the above symbols have a clear operational meaning, also backed by a strong emotional component which is clearly perceived by the bystanders. The ritual dynamics are, in fact, entirely directed towards the creation of a feeling of strong brotherhood among the participants, with full awareness of the obligations this pact establishes. The foundations of this new social relationship lie in the antiquity of the method whereby it is established: 'The

way we found things, we found our grandfathers doing this; and the way we found our grandfathers doing this in the manner of their grandfathers. It is very ancient' (oath of Kienge). It is particularly meaningful given that in another agao group (Kibuka) when somebody questioned the method of swearing by suggesting the oath be taken on the Bible - considered as a modern, Christian oath - the reaction of the others was unanimous. They said that this could not be considered a real oath, according to Tharaka tradition; and, after that, they decided to follow the traditional rule. What is so important in this method, as Tharaka see things, that they consider it the only 'real oath'? I would argue that the key element is the goat: its strong symbolic meaning lies in the fact that it condenses all the values of tradition coming from Murungu and the ancestors. A 'religious' basis is evident in the way the goat is killed: by suffocation, while facing Kirinyaga (Mt.Kenya), the place of God and of the ancestors. Even during circumcision rituals, the candidates are circumcised facing in that direction; and also when a person is buried, traditionally he is made to face Kirinyaga. It is not surprising that it is the goat's blood that makes the oath really effective. Even though there is no particular agent empowered to punish the betrayer, the material consequences of this symbolic link are believed to be really effective (first refrain). Moreover, it is in the nature of a society 'without rulers' that power lies not in a specific authority but in a well-balanced system of mutual obligations. In this light, it is extremely significant that even the new,

modern authorities (in this specific case, the Subchief) are requested to take the oath along with the aqao to ensure the authorities' positive behaviour towards the aqao, and to prevent any harassment ('I cannot get anything to harm them', oath of the Subchief).

In conclusion, if in a cultural element we distinguish the form, the function and the meaning (Barnett, 1940), we can say that in the case of the Tharaka agao swearing-in ceremony the form chosen is totally traditional, namely the oath on the goat (muma ya mburi); and even the function is substantially traditional, to the extent that it is used to satisfy the need for establishing lasting solidarity among people; what appears really new is the meaning attributed to the oath itself. In fact, the function of the oath of overcoming any disagreement and conflict by creating a giciaro, a blood brotherhood, is anything but new:

> 'This oath is taken by those who do not agree. Aqao from old days of our greatfathers were taking this oath when they could not agree one another, when they call each other 'murogi'' (oath of Mbobori).

However, this traditional function is played out in the new context of 'planned cultural contact' to create much more than a peaceful dual relationship: by overcoming any disagreement and feeling of mutual fear among the aqao involved, it makes it possible to establish an entirely new social entity, and thus takes on a new meaning. It is a process of 'reinterpretation', by which new values change the cultural meaning of ancient forms (15). It is no longer simply a matter of establishing and maintaining peaceful relationships between two

competing working professionals; the new values of full cooperation and group formation as a kind of association have substantially altered the cultural meaning of this ancient way of establishing giciaro (blood brotherhood) by oath. The consequences that the introduction of this new element could have on the entire equilibrium of the professional cultural system of the agao appears evident considering the description of the history of the groups (Cf. Appendix I) formed by the oath on the goat.

8.4 Towards a New Professional Statute of the 'Mugao'

The history of the six groups of Tharaka agao (Kitheno, Kibuka, Kamarandi, Kamanyaki and Rwakiemb'ea) formed since 1985 shows the kind of process of self-transformation that a mechanism of social alliance like the giciaro can put in motion. Based on this new brotherhood pact, an ancient individualistic role can change its longstanding character to the extent of creating professional groupings. This can be read, in Landy's terms, as the result of a process of 'role adaptation' stimulated by a 'planned cultural contact'. The introduction of the idea of forming professional groups in order to cooperate with the modern health care system and, what is more important (otherwise one could wonder why this has not taken place before, due to 'free cultural contact'), the production of the necessary subjective, organizational and legal conditions that make it possible (the 'planned cultural contact') have made feasible the kind of 'oriented social change' we have described. However, to describe

this result simply in terms of 'role adaptation', even though it is correct, appears too limitative. We need a new tool of analysis that can help us understand the real nature of the social process of self-development that has taken place among the healers. In order to forge this tool, I do believe that it is possible to trace some 'constants' in the history of the healers'groups, a history which covers a period of about eight years (1985-93) and that, leaving out personal idiosyncracies, we can single out the regularities of this social process.

The first constant lies in the way the groups were formed. This occurred in three different ways: by 'central attraction', by 'agglutination' and by 'segmentation'. In the first type,it is the strong personality and the wealth of a famous and 'well-known' healer that attracts other healers who are probably anxious to gain some benefit: examples of this are the <u>mugao</u> Gichugu with the Kibuka group in its second stage (the first phase of the group is an example of the second type of formation), and the <u>mugao</u> Mukumbu with the Kamarandi group.

The second type of group formation is the 'agglutination' process: here, a set of healers copies others and joins together in a professional group. These are usually 'local' healers who consider themselves all equal: examples of this are the Kithino and Kamanyaki groups.

The third process of group formation is through 'segmentation' out of an already pre-existing group, as in the case of Muthitwa and Rwakiemb'ea groups. The pre-conditions for this are probably a large number of members and internal conflict

within the group.

In all three types of group formation processes the constant remains the need for a gichiaro pact that makes it possible to overcome the traditional mutual fear and mistrust. This immediately gives an 'official' reason for forming the group: to be united and to collaborate. It appears clear that, behind this 'official' motivation, the real personal reasons can be various: to gain status mobility, to affirm one's own leadership, to increase the number of patients,etc.. However, I wish to stress the point that the 'official' reason is not purely rhetorical: as we have seen, the giciaro creates a series of factual obligations whose non-respect is highly blamed and condemned in Tharaka. And this traditional mechanism of social alliance is certainly considered much stronger that a generic statement of social solidarity such as that contained in the official Kenyan national policy of 'Harambee' (16). Certainly, the collective reason for forming the group will then interact with the other, personal reasons: and a certain degree of stability and success of the group will probably be influenced by the consistency or not of this interaction.

After discussing the 'how' and 'why' of the group formation, we can pass on to examine its consequences in terms of internal dynamics. These are strongly influenced by the interaction between the way the groups have been formed and their internal leadership. A group formed by 'central attraction' necessarily needs a strong and authoritarian leadership which rules the group with iron discipline. But, as we have seen in the cases of Kibuka and Kamarandi, this does not automatically

ensure either the good functioning of the group or its stability. Indeed, we can argue that this probably represents the most unstable form of group because of the inevitable frustration and discontent it produces. The 'segmentation' process represents one of the possible outcomes of this situation, as it has happened twice in the history of Kibuka group. This is undoubtedly the most creative solution, probably requiring an authoritative and charismatic leadership, such as that of Rukungi in the Muthitwa group. Where this type of leadership does not emerge, as in the case of Kamarandi group, the internal dynamics of the group continue as before, at least so long as the leader is able to avoid any possibile threat to his personal power. The way the case of Mang'oro was managed by Mukumbu is extremely significant in this respect.

It is probably too early to be able to analyze the internal dynamics of the two youngest groups born out of 'segmentation': Muthitwa and Rwakiemb'ea. However, at least in the first case (which was observed over a period of four years), it is possible to suggest that this appears one of the most promising and stable groups, at least to the extent that the internal leadership remains substantially charismatic. Their past experience in the Kibuka group has probably inoculated the members against many of the mistakes they made before.

Finally, the internal dynamics of the groups formed thorugh 'agglutination' appear more differentiated and difficult to decipher. In the case of Kithino, it seems that this process of formation can result in a series of struggles for supremacy, as

happened in the first phase of the life of this group. This situation, however, cannot persist: sooner or later it will be resolved. In the case of Kithino, the solution was represented by the rejection of the initial authoritarian leadership of Njoeli Muchiri and the subsequent emergence of a 'dual leadership' (Kigwato and Kiaya), whose authority was recognized by the others. The history of the Kamanyaki group is different: the 'agglutination' process did not produce any individual struggle for supremacy as in the Kithino group, but rather an internal conflict between different subgroups. In the case of Kamanyaki these are represented by the oldest and youngest members: and the conflict between them reached an at least temporary solution with the dominance of the youngest subgroups and their 'collective leadership'. But the instability of this solution appears evident: the oldest members follow reluctantly the decisions taken by a leadership they think should be theirs, while among the youngest members the leader's position is too weak and scarcely authoritative.

The constants in the two cases seem to be that in a group formed by 'agglutination': 1) a situation of internal conflict is inevitable and durable; 2) only the emergence of a form of 'democratic leadership' (of dual or collective type) sustained by the majority of members (whereas in both the other two types of leadership, authoritarian and charismatic, the decisions are taken unanimously) can avoid the 'explosion' of the group; 3) in spite of its instability, this form represents one the most promising in terms of subgroup collective action. Is it just a coincidence that the only two groups where some form of 'work-in-

tandem' was proposed and, at least partially, implemented were the Kithino and Kamanayaki groups? What in the other groups could not be tolerated as a threat to the unity of the group itself, in these two more conflictual groups becomes an element to strengthen an internal solidarity, which was otherwise extremely weak.

After examining the consequences of group formation on the internal dynamics, we can now analyze the development produced in the internal regulation of behaviour. Even here it is possible to trace some constants in the life of the groups whose source lies in the collective nature of these new social units. The overcoming of the previous individualistic relationships necessarily requires respect for a series of new rules of mutual behaviour: this implies that a series of customary behaviours traditionally accepted in the relationships of male adults in Tharaka, have now become labeled as 'deviant' and requiring public reprimand within these groups. For example, lateness, absenteeism and drunkenness at meetings; or indiscipline and unregulated talking during a session. It is a series of problems that have greatly troubled the life of all the groups, requiring the embryonic elaboration of a 'code of ethics' by the groups themselves: absenteeism to group's meetings is punished by fine, unless the chairman is previously informed (Kithino); lateness repeated more than three times is to be fined (Kithino and Kamarandi); drunkeness is banned during meetings (Muthitwa); a meeting chairman is introduced to regulate the group's discussion (Kibuka). What appears most

interesting in these rudimentary deontological rules is not the process of their production (based on collective discussion and approval), but the problem of their application. According to my observation and information none of the sanctions or fines was ever actually applied to the transgressor. This probably suggests that even though the rules are there, there is no recognized internal authority yet to enforce them; and that individual behaviour is still expected to be self-regulatory. It is true that all groups selected their officials (chairman, vice-chairman, treasurer and secretary), but these are still considered as "primi inter pares" by the other members, just as were traditionally the agambi (the best speakers) among the other members of the councils of elders (biama bia akuru). This traditionally egalitarian conception of authority is further complicated by the fact that the group's members here are not simply elders, but are also agao. What this can mean in terms of retaliatory power is well exemplified by the story of what happened to the Kamanyaki group (even though there the reason was different). The ambivalence of the mugao's power potentially blackmails any mugao willing to apply any sanction against another mugao. And, moreover, since everyone has his own sins....

The last series of constants we can trace in the history of the healers' groups is related to developments in strictly professional practice. Apart from changing the professional ethics, the groups produced signicant changes in the traditional Ugao practice itself. Crucial here was the decision to build a circular hut in form of a gaaru (the traditional collective hut of the warriors) as a group centre; each of the groups (by a

process of imitation) decided to build but only two have done so till now - namely, Kithino first and then Muthitwa. If the intial decision to join up in groups has influenced the ethical code but left almost entirely untouched the real mugao's work, this second decision has had a strong influence on professional practice. The first issue this decision raised concerned the purpose of such a bulding: was it simply a meeting-centre or a real public clinic? In the minds of many agao,the comparison with modern dispensaries and clinics was inevitable: and, as a consequence, the temptation to imitate the biomedical personnel (even as a status symbol) was great. However, after a lengthy discussion, each group became fully aware of the organizational, economic and hygienic conditions which a public clinic requires. But, instead of putting a stop to the original idea, this further stimulated the cultural creativity of the agao: a group wanted to start a training school for Ugao lasting seven years (Kibuka); another one practised for the first time a simpler form of collective training of an apprentice (Kithino); both these two groups wanted to start in the gaaru compound a botanical garden of the rarer medicinal plants; the same two groups wanted to improve the preparation and storage of their herbal medicines,and accepted that some samples be tested by KEMRI; some members in another group (Kamanyaki) recognized the importance of keeping a regular record of their patients, on the model of a dispensary's register; another group (Muthitwa) kept regular minutes of all the meetings held; all the groups started some form of exchange of knowledge, by discussing the problems they

were most frequently treating; and some of them even experimented a form of 'internal referral system' between two agao for treating the most difficult cases.

Although most of these changes were still only partially implemented, they undoubtely represent a significant shift away from the traditionally individualistic practice of Ugao. Even though actual practice substantially remains an individual matter, the new developments mark an opening and an integration of the customary oral tradition and its ways of inculturation with some new typical features of the written culture and its forms of transmission (school, minutes, ect.) and of biomedicine (safe preparation and storing of medicines, registration of patients, etc.).

I do not think that all the series of constants we have examined can be simply defined in terms of 'role' or 'role adaptation': the reason and the ways of formation of the groups, their internal dynamics, the consequences in terms of 'code of ethics' and the effect on the practical work and apprenticeship, are all aspects that have something to do more with the way a professional role is exercised than with the role in itself. For this reason, I would define the concept that could be used to synthetically analyze all these aspects as a 'professional statute': intending by this term, all the internal elements that define the actual way by which a professional role is exercised. These 'internal elements' are related mainly to three aspects: the transmission of professional knowledge, the relationship with colleagues, the relationship with the client. In the case we have analyzed of Tharaka agao, we can say that the group

formation has significantly affected all these three aspects that compose the 'statute' of a profession: the transmission of knowledge has started becoming collective and assuming the ways of transmission of a written culture; the relationship with colleagues has increasingly become one of mutual trust and cooperation; the relationship with the client has been much more affected by a serious concern for the consequences of a therapy. Therefore, we could say that, stimulated by a 'planned cultural contact', Tharaka traditional healers have undertaken a process of 'statutory transformation' of their profession: a process that involves a series of cultural modifications and innovations that go well beyond a simple 'role adaptation'. Perhaps, in extremely synthetical terms, we could say that from a statute of individualistic and semi-illegal type, they have started to change towards a new statute of associative and legal type. The problem of legality will be fully dealt with in Chapter Ten: here, we can only add that there is an evident relationship (although not univocal!) between individualistic practice and a condition of semi-illegality; as well as between an associated practice and a condition of legality.

Of particular interest, in this process, is the kind of social solidarity that this 'statutory transformation' produces: since it is something that goes beyond the traditional kinship system and the network of alliances based on it, can we argue that we are facing a new type of social solidarity based on professional linkage? In a changing society like contemporary Tharaka, where traditional forms of 'mechanical solidarity'

are increasingly loosening their ties, the need for new forms of social linkage becomes a condition of social unity to avoid the risks of disintegation. In this context, the formation of new kinds of groups on a professional basis enables the establishment of forms of 'organic solidarity' traditionally unusual in a society with a low degree of division of social labour. That these new contents are still nested within the appearances and the language of the traditional elements of 'mechanic solidarity' (such as in the giciaro), is a sign of transition and of a syncretic 'change in the tradition'. Was not it exactly what we expected in terms of 'oriented change' as a result of a 'planned cultural contact'?

FOOTNOTES TO CHAPTER 8

1) Goodenough uses the expression 'social identity' to denote 'an aspect of self that makes a difference in how one's rights and duties distribute to specific others' (1965:3), in other terms by referring to social positions. He also clarifies the difference between this and the 'personal identity', considered as the personal style, made up of emotional orientations and the different ways one chooses to exercise social identities (ibid.:4).

2) Some anthropologists have tried to rethink the concept of role beyond a traditional structural-functional approach: among others, of particular interest is Goodenough's essay (1965) inspired by structural linguistics.

3) As is well known, individuals in any sociocultural system are confronted with 'overdemanding' role obligations (Goode, 1960:485), and must manage to balance role relationships and role sets by continually bargaining with other actors, and consequently reducing role strain.

4) (Landy,cit.:469). In situations of rapid social change,healers, like any other traditional role, are confronted with a series of competing demands for alternative possible behaviours (either internal or external to the indigenous social system), whose potential stressful consequences are reduced through a continual bargaining with other social actors in order to manage a minimum consensual equilibrium in role relationship. This approach by Landy is based on four assumptions: 1) the curer's role in traditional societies was socially acknowledged and relatively secure from any social change; 2) prior to cultural contact, this role was also oriented towards status achievement, expecially in competition with other curers; 3) role performance expectations were shared by healers along with other members of their society, and the reasons for competition originated primarily from within the professional group itself, presenting a relatively stable and controlled range of possibilities; 4) finally, whether curer's role was part- or full-time,its prestige was reinforced by the other social identities and statuses of a 'social persona'in a complex of 'role sets' and 'status sets' (Merton, 1957). The concept of 'social persona' as used by Goodenough indicates the composite social identities selected as appropriate to a given situation and which are usually in a relationship of compatibility with each other (Goodenough,1965:7).

5) Landy's analysis sounds very interesting in that it proposes a non-stereotyped conceptualization of the curing role in non-Western societies, recognizing its relevance and features: 'The indigenous medical role may carry as much, and at times more, power,prestige and responsibility as the medical role in Western society. (...) Therefore the label of "professional" should not be confined to scientifically trained personnel' (Landy,cit:477).

This important assertion about the nature of the healing role is furtherly endorsed by the acknowledgement of the great measure of flexibility in the implementation and interpretation of this role. Even though Landy is still convinced that such a role is essentially conservative - because he 'has a crucial stake in the maintenance of the indigenous culture, for the more closely it begins to approximate the donor culture, the more vulnerable the role becomes' (ib.:478) - he in fact recognizes that it represents 'one of the roles more sensitive to the pressures for change in any social system' (ib:468). Therefore, why deny the possibility of this role becoming a change agent and a cultural innovator? Landy, in fact, assumes that, on a psychological level, if role adaptation to cultural strain is to be achieved, it must be accompanied by cognitive adjustments: besides social realignments of interpersonal relationships, the curer must be able to deal successfully in cognitive terms with the ever-increasing flow of new ideas, behaviours, and technological changes. This requires a tolerance of cognitive dissonance and a capacity to 'compartmentalize' (Goode,1960) dissonant values and role requirements. The result of this will be that,'The traditional curer who achieves a viable role adaptation not only retains the indigenous community as his major membership group but also claims it as his basic reference group. (...) It is from the culture of his membership group that he draws his sanction as healer,and from the maintenance of its values and practices that he retains his legitimation of his role'(Landy,cit.:478).

6) The notion of the 'cultural broker' was first explored in the seminal paper by Wolf (1956) on the mediating functions of the politician role between local and national institutions in Mexico; then Geertz (1960) proposed an interesting analysis of the changing role of the Javanese kijaji as Muslim religious teacher and nationalist politician; this was followed by Press' examination of the role's ambigous and innovative features (1969b).

7) Particularly in the case of new roles, it is believed that those for which analogous roles already exist in the host culture will be most easily accepted. As Alland states it, 'When analogous roles exist in two different behavioural systems, change need only involve a change in the content of existing roles. When no such analogs exist, change may require the adoption of an entirely new role or set of roles' (Alland, 1970:157).
According to Landy (and in my opinion,too), 'it should also be assumed that those roles that provide no, or a negative, analogue to the Western medical role stand the greatest chance of survival and are least in need of change in the interest of adaptation' (Landy,cit:479). I am strongly convinced that the curing role in traditional societies has features that have no analogue in a Western medical system.

8) This well-known functionalist approach, which considers the

role as being composed of a series of functions performed in a social system, each constituted by a certain number of activities which can be divided, at the the most concrete level, into tasks, or simple actions.

9) In this respect, 'status' is considered as the 'allocating' aspect of a social identity or position; whereas 'role' corresponds to its 'prescribing' aspect.

10) Contrary to Parsons' opinion that regularities exist only in synchrony (Parsons,1937), Barnett (1940) thinks that it is possible to trace a certain number of 'regularities', not real 'laws', even in the social and cultural dynamics, that produce a sort of cultural and social determinism.

11) The notion of 'cultural trend' is derived from Sapir's idea that language changes over time according to its internal tendency: by extension, every culture follows its own orientation, which is ascribed in the past and foresees the future (Bastide,1971).

12) That the incorporation of traditional healers could really represent a form of status advancement has been considered doubtful by various scholars, including myself.

13) This individualistic and competitive feature is typical of many healing roles in African cultures: perhaps, it is possibile to hypothesize a connection between these features and the 'little tradition' of medicine in these societies.

14) As is known, Durkheim's idea of 'mechanical' and 'organic' solidarity is based on different levels of the division of labour in a society and on the different degree of interdependence it produces (Durkheim,1893).

15) There is, at least, another well-known case of reinterpretation of this traditional cultural element: the Mau Mau movement. Even though detailed historical study of this rebellion movement - whose grassroots were among the Kikuyu, Embu and Meru of the Central Higlands - has not been undertaken yet,we know that one of the central elements of its activities was the oathing. The organization of oathing on a large scale was probably the way by means of which the movement achieved a large mass support: even in this case, the new political meaning of the oath was attached to the old form and function of this cultural element. On Mau Mau, see Corfield's (1959-1960) and Rosberg and Nottingham's (1967) interpretation as a nationalist movement, and Barnett and Njama's (1966) and Oginga Odinga's (1967) intepretation as a peasants'revolt caused by agrarian grievances.

16) The Harambee Self-Help Movement has been launched by President Moi in post-independence Kenya in order to mobilize community resources to achieve local development with little involvement by the State.

CH.9 JURISDICTION-BASED COOPERATION WITHIN THARAKA HEALTH CARE CONFIGURATION

9.1 Medical Pluralism or Biomedical Dominance?

The second aim to be achieved by the Tharaka Project in terms of 'oriented social change' was to foster the articulation and cooperation between indigenous healers and biomedical personnel. By a series of stimuli which I am going to describe (the 'planned cultural contact') the expectation was that a process of modification of past attitudes and behaviours on both sides would have developed, producing the beginning of a new type of mutual relationship. The legal and political aspects of this process are discussed in the last chapter; here, we shall concentrate on cultural and social aspects of the problem under discussion. This requires tackling a number of theoretical issues whose clarification is essential if we are to avoid at least some of the many ambiguities and inaccuracies with which this topic has been plagued.

The first (and probably foremost) issue regards the nature of the relationship existing between the two sectors of indigenous medicine and biomedicine within the same health care system. When, as in most of the current literature, the expression 'medical pluralism' (1) is used to refer to the whole range of medical resources available to and utilized by a community, it seems that health care systems can be just thought of and described as atomized constellations of 'several types of practitioners each with its own social and economic context and

intellectual heritage' (Janzen and Feierman, 1979:242). Though this can be a useful research tool to identify the whole range of therapeutic options available in a community or in a country (2), it becomes certainly misleading when used to analyse such range. The implication is that 'all medical systems can then be conceived of as pluralistic structures in which cosmopolitan medicine is one component in competitive and complimentary (sic!) relationships to numerous "alternative therapies" ' (Leslie, 1980:191). This 'liberalistic' view of medical system is totally deceiving, since it does not consider at all the real power relationships and the institutional aspects within such system: that, nowadays, a 'plurality' of options exists in practically all the medical systems, it does not automatically mean that it is possible to qualify them as 'pluralistic'! This term would imply that none of the options holds a position of structural superiority over the others, all being on equal level. This is curious when we know that in Africa, as elsewhere, even the most secluded local health care system is part of a state-based medical system, where the biomedical establishment is powerfully represented in health ministries. The consequence is that, in the division of labour existing in every medical system, biomedicine is in a position of actual structural superiority. I can argue that the best concept to describe such situation is not certainly 'pluralism' but 'dominance': intending by this term the position of structural and cultural hegemony hold by biomedicine in state-based medical systems (3).

Consequently, talk of 'cooperation' between indigenous

healers and biomedical personnel in African countries without taking into account the imbalance existing between these two sectors as a result of the biomedical dominance, is scarcely honesty. It is an illusion to believe that unorganized scattered individuals can properly work together - on equal terms - with a powerful, government-backed and financially much stronger institution like biomedicine without forfeiting their own autonomous position. Not taking into account this institutional imbalance is totally misleading: unless, under the label 'cooperation', one has in mind something else than a mutual collaboration on equal terms.

This brings us to the second issue which deserves discussion: that is, the meaning attributed to the term 'cooperation'. It is my impression that, if we review the current literature on the subject, this term is variously used by authors with at least four different underlying meanings: 'collaboration', 'incorporation', 'integration' and 'articulation'. The first meaning is traceable, not only in most of the WHO documents anxious not to hurt the delicate ears of the biomedical establishment, but also in most of the writings and actual practice of pharmaceutical institutions, empowered by national governments with the task of testing traditional pharmacopoeia to produce new national drugs. The real meaning of this form of 'cooperation' is in practice little more than simply an occasional or marginal coexistence, as shown by my direct experience with KEMRI (Kenya Medical Research Foundation) in Kenya. The healers are just an object of attention to the extent they can be despoiled of their 'secrets' about herbal

concoctions: then they are simply liquidated as 'quacks' (if the findings are negative) or lured in as 'collaborators' (if the findings are positive).

The second meaning is much more reliable, though still questionable: it underlies most of the current and past literature on 'utilization' of indigenous healers in national health systems (4). The option here is the incorporation of traditional healers (and other practitioners) as part of the local team in every rural health outpost. The sort of problem that this raises among biomedical staff is obvious; moreover, I agree with Carol MacCormack when she wonders 'Why any respected local practitioners would want to join a national health service in its lowest ranks' (MacCormack,1986:154). However, it can probably work where formalized institutions were already part of traditional medical systems, as in the Indian (Ayurveda, Unani) or Chinese situations (5).

The third meaning is mostly implicit in the literature and experiments of transcultural psychiatry, where the therapeutic practices and ideas of indigenous medicine are paired with modern psychiatry to form an unorthodox hybrid system for treating a wide range of mental disorders (6). Even though the syncretic result of this integration is often very interesting, it is undoubtedly the result - difficult to generalize - of particularly innovative medical practitioners, such as Dr.Lambo's community-based psychiatric therapy in Nigeria which we shall describe below.

The last meaning - the one I advocate - intends cooperation

as a way of articulating autonomous bodies of knowledge and personnel, each one without losing its own autonomy and independence. It is to take the chance of going beyond either any deceptive 'collaboration' and 'incorporation' resulting de facto in assimilation when the structural imbalance is too wide, or 'integration' based on particular idiosyncratic personalities (7). The biggest problem for this conception of cooperation is that when traditional medicine, as in the African context, is not characterized by formalized institutions such as in the Asian 'great traditions', to postulate an equal working partnership becomes difficult and it should not be taken for granted. However, this institutional imbalance we discussed before can be overcome, I believe, on two conditions: 1) that the healers start a process of self-development that gets over the traditional competition among themselves by the formation of professional associations which take care of their interests and act as 'pressure groups'; and 2) that they become part of a network of collaborative relationships at the community level that can bring out their specific role in respect of the other non-professional health care providers (village health committees, community health workers, traditional birth attendants,etc.). The first condition has already been illustrated as the first aim of the Tharaka Project in the previous chapter; the second condition will be illustrated in the next paragraph, after discussing the issue in more detail here.

This brings us to the third ambiguity in most of the current literature and experience about 'cooperation': the more or less total absence of consideration of the role that popular health

care (intended mainly as family-based and community-based health care) can play in the articulation of biomedical and indigenous sectors. If some of the major strengths of traditional medicine are its availability and accessibility in the community and its acceptability as an integral part of the local culture, why should not this basic linkage be properly fostered, becoming the pivot around which to hinge the whole cooperation system? Most of the medical work of the healers takes place in the village while that of the doctors and other biomedical personnel is performed at specific locations (dispensaries, health centres) or at the district level (hospitals): besides the problem of institutional imbalance we saw, this means there is a real 'spatial gap' that can seriously hinder any effective partnership. Not only have we particular individuals (healers) facing a larger institution (biomedicine) as their partner; we also have a problem of practitioners working at different territorial levels.

To conclude, I believe that, when talking about 'cooperation', it would be more appropriate that everybody should clarify the real meaning attached to this concept, with particular reference to: 1) the way the relationship between biomedical and indigenous health care is considered; 2) the actual way this cooperation is to be achieved; 3) whether or not the context of popular health care is to be considered in the collaborative process. The clarification of these three issues will probably help to spell out what sort of achievements we are going to aim for; and, above all, to understand the drawbacks and the failures we have inevitably to face when confronted with

human behaviour.

9.2 The Two Levels of Cooperation

As I have pointed out, the institutional imbalance that hinders any effective process of cooperation between indigenous and biomedical personnel could be at least partially overcome by creating two 'counterweights' with the aim of counterbalancing the lack of balance: 1) the formation of professional associations by traditional healers; and 2) the involvement of the local community. With this research hypothesis in mind, we should break up the issue of 'cooperation' (in the sense of 'articulation' as we have given it) into two main levels: 1) as a problem of 'interprofessional relationship' between those holding the two different jurisdictions of biomedicine and healing; 2) as a problem of 'community involvement' on which to ground any process of cooperation whose impact could be significant for the health of the community itself. These can be considered as the two main dimensions of our problem: whose articulation becomes essential in setting up any cooperation which is not simply a top-down process. We shall first deal with the second dimension by examining the Tharaka experience in order to make clear the sort of problem entailed.

The 'community dimension' of cooperation is grounded on the people's health-seeking behaviour: by analyzing it (see Chapter Three), we have understood that their 'unified view of illness' implies an integrated utilization of popular, indigenous and biomedical health care resources. This is because in any illness

episode two different etiological planes can coexist: the natural one, implying physical forces either in the body or in the environment; and the non-natural, involving social and spiritual forces external to the individual. Consequently, the complementary utilization of a plurality of available therapeutic options arises from the well-rooted conviction in Tharaka that biomedical and popular sectors of health care are properly associated with the first plane, whereas indigenous Ugao is well suited to treat the etiologies of the second plane. However, both therapeutic choices can be selected within the same illness episode: both can be considered as necessary for complete healing to occur.

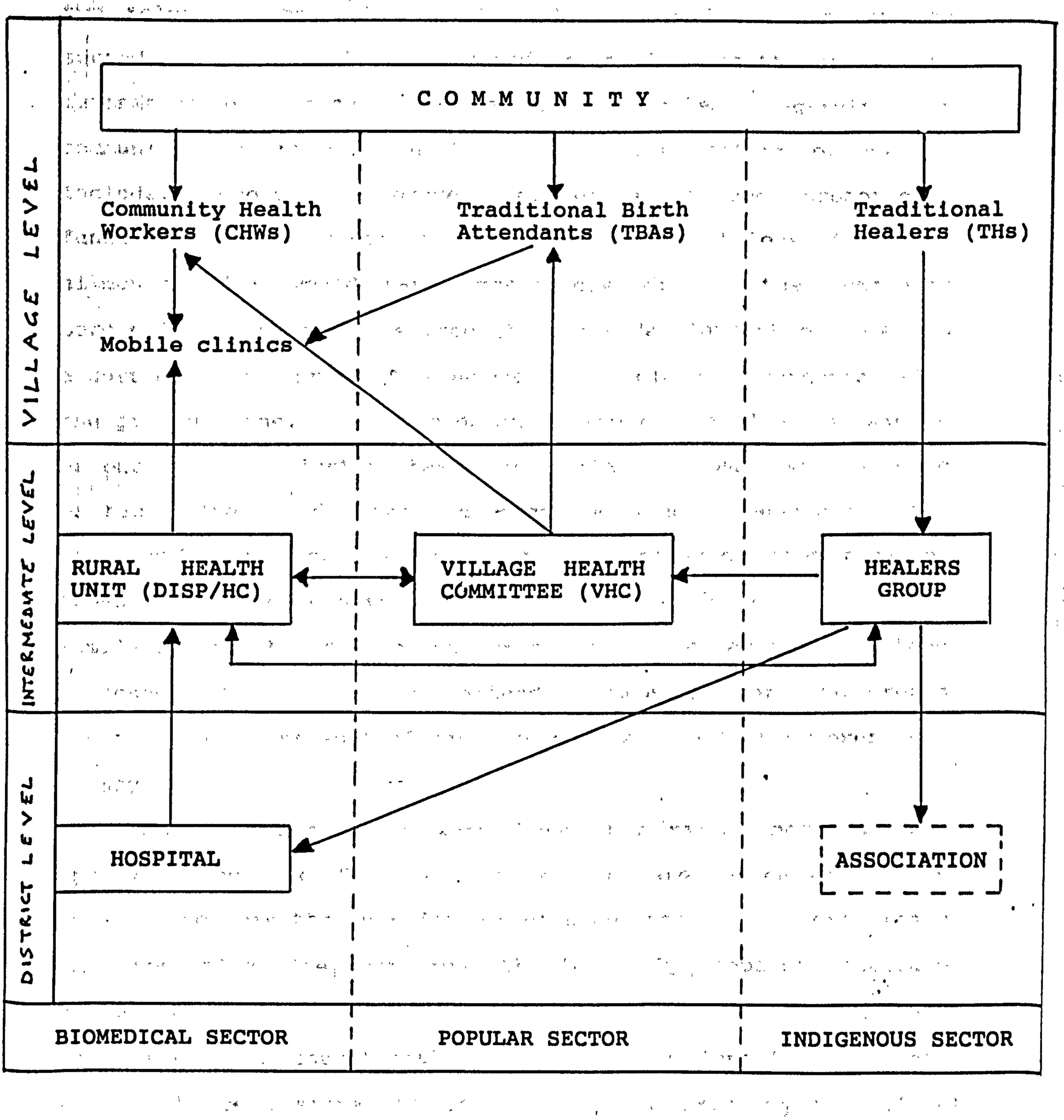
This 'plurality of health care resources' (8) can be considered the starting point of any cooperation process: since a form of integration already exists - rooted in people's minds - it should be much simpler to 'rationalize' an already existent cultural element than creating a new one. 'Rationalize' here could mean to give formal aknowledgement to an informal process: in other words, to make people openly reflect about a more or less unconscious (mostly culturally determined) behaviour. This is in order to identify the shortcomings, the drawbacks and the effects arising from it in terms of health needs. The 'cognitive structure of illness' used by Tharaka people to choose among different alternatives in health-seeking behaviour becomes in this way a guide for the creation of a well-grounded cooperation system whose aim is mainly to improve people's health in the community.

If these were the theoretical premises, how were they put into practice? The 'Rural Health Care Project' run by Nkubu Hospital in Tharaka was the applied context of cognitive results achieved by the research studying people's health-seeking behaviour and the healers' work. The programme in its first phase (1978-1984) consisted of running periodic mobile clinics to some places and monthly visits by doctors to supervise the two dispensaries of Marebe and Materi in South Tharaka. The first stimulus introduced by the research in term of 'intervention level' was the suggestion to focus attention on the local community and its needs. This could have been achieved through the creation of local 'Village Health Committees' (VHCs) by the community with whom the biomedical personnel could interact. After a series of contacts with the local authorities (Chief, Subchief, headmen) mediated by the researcher, the first two committees were formed at Tunyai and Kamanayaki during <u>barazas</u> (public meetings), each composed by the headmen of every 'unit' (Kenya's smallest administrative entity, roughly corresponding to a scattered village) and a prominent person selected by the people for every unit (either a man or a woman). In the <u>barazas</u> the common people discussed the health problems in their areas, identifying some gross needs. The aim and the methodology of the project to be started were discussed with medical personnel (doctors and nurses) of Nkubu hospital. A particular stress was put on the role of community organization and mobilization of the committee,and the representation of local health needs. The final assignment of each committee was the proper selection of local motivated people to become 'Community Health Workers', voluntary

persons who were to act as health educators and helpers in the community. The composition of each committee should have guaranteed that both formal authorities (the headmen) and informal leaders (the prominent persons) were equally involved in this process of selection, avoiding as much as possible any favouritism and ensuring the necessary support for the subsequent work of the volunteers. In the subsequent meetings with the two newly formed committees, the volunteer candidates were introduced: their work was discussed with a particular stress on its voluntary character. Before starting any training, a 'role-analysis approach' (9) was suggested by the researcher to avoid any ready-made package, as is usually offered by biomedical personnel.

Besides being used for setting priorities in training, the role-analysis technique was an extremely useful tool for the articulation of a collaborative network at the community level (fig.9.1). The identification of the different functions played by each role was the basis on which to approach the issue of cooperation at the community level. The least problematic was the articulation of the TBAs'role: since their work was specifically circumscribed to the female spheres of pregnancy, delivery, post-natal care and family planning, their traditional assistance and advisory functions in this sphere needed only to be integrated with a proper referral system for complicated and at-risk cases. This was achieved by the training course and the mobile clinics run periodically by the hospital or the dispensaries at village level.

Fig.9.1 A Comprehensive Model for the Articulation of a Pluralistic Community-based Health Care Configuration



More problematic was articulating cooperation with the other two roles of the CHWs and THs. Since the first, unlike the second, was a newly introduced role in health care, its definition gave rise to a series of problems regarding its community perception. The first issue was whether or not to include, beyond its preventive, educative and promotional functions, also some sort of curative function at least for minor ailments. This would have immediately shifted the community perception of this figure from that of a development promoter to a sort of 'mini-nurse'. The second issue, closely connected with the previous one, was the problem of reward: if this job was to be purely on a voluntary basis, what kind of reward was there to be had? The third issue concerned the kind of authority this role could exercise over his mates, considering that most of these volunteers were young educated persons: for example, if a family did not build a toilet, or did not clean the homestead compound, or failed to attend regularly for children's immunization, what sort of sanctioning power could they exercise, if any ?

These three problems were frequently raised more or less openly by people during the <u>barazas</u>: they are indicative of the sort of problems the introduction of a new social role can create in a community. They confirmed the initially sceptical attitude of the researcher towards this role: his original idea was that the preventive, educational and promotional functions of this role could be assigned to the two already existing traditional roles of the <u>ajukia</u> (TBAs) and of the <u>agao</u> (THs). But then, the

limited sphere of influence of the ajukia (confined to the female world) and the professional nature of the agao's work were convincing reasons for the need to introduce this new role of change agent. However, the problems remained; moreover, the introduction of any kind of therapeutic function (although limited to minor ailments) would have created an objective overlapping and competition with the agao. For this reason, no such function was assigned to the role of CHW. The voluntary nature of the work of this figure was stressed in order to differentiate it from that of the agao. The problem of the reward was settled in terms of motivation towards social prestige and some material advantages, either collective (such as the utilization of ploughs) or individual (such as the delivery of a special card to every CHW for free admission to the hospital). The community perception of the authoritative character of this figure was supported by the intervention of the VHCs members, whose leadership and authority supported the work carried out by the CHWs.

Some problems, however, remained in the relationship with the agao: the VHCs established that a representative of the agao groups existing in Kamanyaki (Kamarandi and Kamanyaki groups) and Tunyai (Kithino and Kibuka groups) would participate in the committee meetings. Nevertheless, their presence was always problematic for at least some committee members who more or less openly opposed it. On the other side, the agao (at least the most 'well-known' of them) thought of themselves as a special category, whose role in the cooperation project was well above

that of ordinary community members, especially because the local community was not really their main concern. This created some problems, especially when the issue was raised whether or not the VHCs should supervise the activity of the agao, just as they did the TBAs and the CHWs. It was decided that the work of the agao should remain totally autonomous, given its professional nature; and that only for referral of difficult cases would they collaborate with the VHCs and the other figures. In any case, the committees proved to be the most appropriate loci for discussing these and other matters regarding cooperation at community level and for acting as a binding force between this level and the professional health workers, either biomedical or indigenous ones.

After pointing out the second dimension of the problem of cooperation, we have now to deal with the first: this is represented by the 'interprofessional relationships' between indigenous and biomedical specialists. Though this aspect is closely connected with the other one (especially, as we have seen, for the implementation of a referral system), there are some specific aspects related to the professional nature of the partners involved - that is, to the jurisdictions held by each of them - which need to be dealt with in particular.

I have already illustrated the two stimuli introduced by the research as forms of 'planned cultural contacts': the idea of the 'group formation' of the agao and the 'community focus' as a re-orientation of the Rural Health Care Project of Nkubu Hospital. The third and final stimulus was the idea that some sort of

'inter-professional relationship' between indigenous and biomedical personnel was possible. Sceptics rightly argue that a lot of political, legal and organizational factors (which will be dealt with in the next chapter), quite apart from cultural ones,can testify to the naivety of this idea. However, as Ojanuga shows in his study of a Nigerian case,'The data suggest that both medical and traditional doctors are in favour of an integrated system, but practical and conceptual differences may hinder the successful adoption of such a policy' (Ojanuga,1980:89). It is important to stress the basic importance of positive reciprocal attitudes as the starting point of any cooperation process; since 'the success of an integrated policy would depend partly on the willingness of medical and traditional doctors to work together' (ibid.:86). Then it will be necessary to point out all the 'practical and conceptual differences' that represent as many hindrances in the way of an effective cooperative system; taking into account that the matter involves as much medical doctors as the other biomedical personnel (nurses, midwives, technicians, public health officers,etc.), whose attitudes and roles should not taken for granted. This is the path it was pursued by the three-stages strategy followed in the Tharaka project, as I describe it in Appendix D. On the basis of the described work and its findings, I shall now try to draw some conclusions.

1) By comparing the sixteen therapeutic treatments, it is possible to show there is a high degree of standardization in Ugao practice, which suggests that they are not the product of personal idiosyncracies but contain a series of recurrent symbolic (actions, objects, spells,etc.) and non-symbolic

elements (herbs and concoctions) whose meanings and functions have been established by a professional tradition. Only a few cultural elements have been introduced by individual agao as a result of actual innovation or new formal elements based on traditional functions (for example, the use of padlocks based on the traditional function of 'closing'). It seems as if there is an ancient central corpus of knowledge, represented by what the Tharaka agao call the 'Old Ugao', which is continously amended and augmented through personal creativity and cultural innovation. In this respect, cultural contacts are anything but new for Tharaka agao, some of whom started travelling outside their home area in the 1940s, and widening their professional background by undergoing new apprenticeships, especially among the Kamba and Coastal peoples like the Giriama, Atinku and Digo.

During training, the healer not only learns a sequence of practices and ritual instruments for mechanically treating certain sicknesses: he also learns to understand the specific problem each patient presents, his social relationships, so as to investigate and deal with the 'invisible' powers of sickness, and adapts his own paraphernalia to the different circumstances in which he finds himself working (the presence or absence of certain elements, as well as different spatial and temporal conditions). In other words, he has to learn how to use his imagination and cultural creativity, to be intellectualy flexible. Therefore, a high degree of standardization does not mean an absence of individual creativity and freedom: the latter will depend largely on the interaction of individual

healers' personality and the extent of his professional background with the patient's characteristics and the particular circumstances and settings in which the treatment is performed.

2) Ugao practice showed a high degree both of internal and external consistency. In fact, there was no contradiction between the elements used by different agao to treat the same problem and their meanings and functions. As it has already been pointed out, this did not exclude a certain degree of individual difference due to personal creativity. However, what matters here is that this consistency allows the singling out of an actual 'system' of knowledge and practices. Such system - which probably corresponded in its most ancient boundaries to the 'Old Ugao' mentioned before - is also externally consistent with the 'cognitive structure of illness' that underlies Tharaka people's health-seeking behaviour (see Chapter Three). The two etiological levels pointed out during our analysis of the Tharaka unitary view of sickness, also underlie the Ugao. The clearcut distinction between, on one hand, aspects of the same illness episode that require divination - since their causes are unknown and 'invisible' ('muringia onaga mbuguni', the diviner 'sees' in the mbugu, the divining instrument) - and, on the other hand, aspects that do not, since their etiology is 'visible' and known by the symptoms perceived, is replicated also in Ugao. Therefore, there is no contradiction between popular and professional ideas and behaviour regarding health care in Tharaka culture traditionally.

3) The identification of possible 'areas for intervention' and

cooperation follows from this. If the 'invisible' etiological level is the pivot of Tharaka health-seeking behaviour, any form of cooperation that respected this view (since it is culturally founded and not harmful) should start from the same perspective. From a lay perspective, the interaction between Tharaka and Western therapy can assume three forms, according to the level/s of explanation believed to be involved: a) exclusive, when the level of explanation involved is believed to be within the competence of only one type of medicine: for example, the Ugao for culture-bound syndromes such as urogi or kirumi, or biomedicine, for surgical operations; b) supplementary, when, conversely, both types of medicine are believed to be relevant for the level of explanation involved, and their therapies actually compete, with a possible problem of the drugs interacting: an example is the case of the 'natural' explanation for endemic problems such as malaria, diarrhoea and worms, where both types of medicine can be used, and popular medicine too plays a role (home remedies, shop drugs, etc.); c) complementary, when an illness is believed to involve two levels of explanation, each level the competence of a different type of medicine, with both considered necessary for complete healing to occur (such as in the clinical case n.4 of Karimi, when the mugao treated the urogi and the hospital the pyrexia, see Appendix D).

We can thus argue that in the Tharaka health-seeking behaviour there is not a single form of relationship between indigenous and Western medicine: in fact, the duality of etiological levels involved gives rise to a plurality of levels

of relationship, based on the specific competence of each type of medicine. The three levels of relationship (exclusive, supplementary, and complementary) and the related spheres of intervention can represent the cultural foundation of any well-rooted and articulated cooperation project. Instead of altering existing behaviour or creating new ones, it is just a matter of 'rationalizing' what people are already doing when it appears problematic for their health. This means, for example, that when the diagnosis are of the exclusive type, the best way to cooperate would be to set up ways of effectively referring patients, so as to avoid any dangerous delay. In the case of a complementary diagnosis, each type of practitioner can intervene with full awareness that his work is considered insufficient on its own and needing in addition the other kind of intervention, which he should encourage as much as possible. When, finally the diagnosis takes the supplementary form, cooperation appears more problematic, especially in cases where there is a risk of interactions between the different types of drugs. In this case, cooperation should probably take the form of a joint workshop, where both types of practitioners involved can discuss their work and its reciprocal effects.

4) The project was undoubtely insufficient for a full understanding and evaluation of the therapeutic effectiveness of Tharaka Ugao. Indeed, this was not the main purpose of the work. However, the second phase of study along with the apprenticeship I was doing at the same time as a mugao, permits, I believe, some initial observations on the therapeutic value of Ugao, some of which I have already mentioned in Part II (see 7.2). Most of

these observations are based on the therapeutic results recorded from patients (see 3.2), and on the many sessions held with the doctors of Nkubu hospital.

Our starting point is the conception of therapeutic effectiveness already discussed, which considers it as the result of the interaction of multiple planes of explanations, each playing a role in a holistic approach to the illness that goes well beyond a purely physiopathological and technical explanation. In this respect, of the four levels of efficacy we included in our model (biological, psychological, social and extra-normal), we could say that the Tharaka Ugao shows a particular therapeutic value in terms of psychological and social effectivenes: its rituals play an important therapeutic function for mental problems by such devices as the use of suggestion and manipulation through symbolic actions, objects and spells whose meanings are culturally founded; and the same rituals represent in most cases a form of social support for the sick person (as in the case of infertility), or of social control (as in the case of Kirumi or Urogi rituals). We can also probably suggest some form of extra-normal efficacy, acting especially during the divinatory sessions, when a metagnomic power of knowing is used by the muringia. It is at the biological level that the problem remains mostly unresolved, since the results of KEMRI's pharamacological analysis were incomplete. More studies on Tharaka medicinal plants and herbal concoctions will be needed (see Apppendices E and F).

9.3 A Comparative Perspective

I like to end this chapter on the Tharaka experiment in cooperation with a wider comparative focus on similar projects in the African context. This will allow us to single out similarities and differences in order to put into context the peculiarities of the Tharaka experience. As Good (1987:302-10) and Green (1988:1125) point out in their most recent surveys on the topic, published information about active and working projects in Africa where indigenous healers (and not simply TBAs) are actually included as a part of health care programmes appears very limited. The above authors can list seven of them: one is defunct (Lambo's pioneer Aro programme of community mental health which started in 1954); two still appear to be in either the planning or earliest implementation stage in Nigeria (the Programme in Benue and Lagos States and the other one in Araromi); two are stalled (the PRHETIH Project in Ghana and the collaborative project for healers in Swaziland focusing on oral rehydration); and only two district-level projects are still functioning in Ghana, in Dormaa and Berekum. In Kenya, only a short, preliminary programme for training the urban waganga (healers) was attempted in Nairobi in 1980: 24 waganga attended at the Community Health Department of the University of Nairobi some lecture sessions by medical doctors on heart, basic paediatric problems, diarrhoea, first aid and body anatomy and physiology (Kimani,1981:421). However, this encouraging attempt had no follow up. Since in all these programmes the only two which are well-documented and took a comprehensive approach are

the Ghanaian PRHETIH and Dormaa programmes (10), I shall now concentrate on them, discussing the differences between them and the Tharaka one.

Apparently, the two projects are very similar in their design: in particular, the contents of the syllabus are almost the same (Tab.9.1). However, it is possible to point to some substantial differences between them. The first difference regards at what level and between whom cooperation is established. As Helga Fink puts it,

> 'The PHRETIH project and the DHP answer these questions differently. In contrast to the PHRETIH project which attempts to achieve cooperation between healers and hospital personnel (doctors and nursing staff) at the district level, the DHP concentrates its attempts on the integration of traditional and modern health care personnel (village health workers/healers) in the villages' (Fink,cit.:40)

Even though we cannot always take for granted the words of someone actively involved, nevertheless we can consider this difference of approach as rooted in fact. In the PHRETIH cooperation is basically a matter of the joint working of healers and doctors, their connecting institution being at the district level - that is, an instituzionalized form of working cooperation where only two professional spheres are involved. By contrast, the DHP is characterized by a community focus where cooperation is thought of as a joint effort between all those (mainly, healer and VHWs) engaged in a process of mobilizing all basic health resources at the village level.

This difference in approach brings us to a second difference regarding the relationship between the two types of practitioners. The basic issue here is the problem of biomedical

Tab.9.1 Syllabus of Dormaa Healer Project (Ghana)

1. Hygienic preparation, conservation and preservation of medicinal plants;

2. diseases, their diagnosis, therapy and causation in modern and traditional medicine: measles, tuberculosis, diarrhoea, malaria, hepatitis, malnutrition;

3. nutrition: nutritive value of different types of food; proper feeding of children; preparation of plant protein concentrate;

4. mother and child: pregnancy, delivery;

5. direct preventive measures: traditional and modern methods of vaccination;

6. indirect preventive measures: environmental and human health.

Note: From Fink,1989:331.

Tab. 9.2 Dormaa Healer Project: Indicators of Effectiveness

- Continuity of participation;
- satisfatory test results as an indicator for learning processes;
- implementation of the newly acquired knowledge;
- participation of the healers in health activities in their communities;
- initiation of new health measures;
- professionalization.

Note: From Fink, 1989:333.

dominance we discussed at the beginning of this chapter: what is the stance of each project toward this fundamental issue? The PHRETIH seemed to overlook this problem, taking for granted the attitudes of biomedical practitioners (especially paramedical personnel) and postulating the existence of an equal working partnership. The consequence is that 'It is a fact that healers who take part in the PHRETIH project complain that doctors and hospital personnel continue to show a lack of respect to them and do not accept them as colleagues. Furthermore, patients sent to the hospital by healers receive no special attention and neither diagnoses nor treatment are discussed together later' (ib:42-3). Although the DHP is conscious of the existence of this institutional imbalance, it also does not seem to tackle it: it simply postpones any form of cooperation between healer and doctor to a time when two condition will be fullfilled: a 'cooperation among the healers and between healers and modern health personnel in the villages; (by the) professionalization of healers and the formation of a professional organization for traditional healers' (cit:43). Fink refuses to consider healers projects as part of Primary Health Care and thus of modern health care, since this puts them in a 'weak bargaining position' 'as a result of their structural inferiority' (ibid.); she hypothesizes a 'multi-functional integrative system of health care' where the three health institutions - hospital, PHC, traditional medicine - can coexist, institutionally independent from one another, in a new type of national health care system.

A third problem is related to the consequences of the two

approaches in terms of attitude towards the healers. In the PHRETIH, a particular stress is put on the transmission of modern medical knowledge and on changing the medical practices of the healers; whereas the DHP draws on 'on the functional strength of traditional medicine and its practitioners and attempts to further expand this strength, starting in the villages' (ibid.:41). Although it is stated that 'special emphasis is placed on traditional methods of treatment. These are only modified and complemented when absolutely necessary or when the healers themselves so wish' (ibid.), no practical example is given to prove this. Consequently, we do not know whether this difference is real or has just remained in the mind of the Dutch anthropologist.

The last problem concerns the relationship between healers and village health workers. In the PHRETIH project this is not included, since it does not work at village level. In the DHP, the starting point was

> 'the observation that health workers and traditional healers in the villages are members of the same community and are confronted with each other as colleagues. They both offer parallel basic health services to villagers according to the means and methods of their respective medical backgrounds. Real professional contacts between the two have hardly taken place up to now and, for this reason, plenty of prejudices exist on both sides' (ibid.:40-1).

It is my opinion that this 'professional' qualification of the village health workers is rather questionable: after all, though they can be considered part of the modern medical system being 'its executive agents in the villages', the voluntary character of this role and their belonging to the local community (of which they fundamentally still share the culture!) makes

them a syncretic figure, an interface between the institution and the people. And we know that their young age and low social status often hinders this role of go-between; this is in contrast with the healers, whose reputation and social standing are more important - and make them heard in matters of social health - than just the support of 'a faraway institution, the organization and aims of which are incomprehensible to the majority of villagers' (ibid.). For these reasons, we learn with some scepticism that the inclusion of the VHWs in the training course, side by side with healers, was so successful and gave rise to no serious problem. According to my Kenyan experience, this would have been highly problematic, as the difficulties I referred to (see 9.2) suggest.

In conclusion, I wish to compare the Tharaka Rural Health Care Programme with these two projects. In short, we can say that whereas the PHRETIH project follows an 'institutionalized professional approach' to the issue of cooperation at district level, the DH project represents a 'community-based approach'. Both these two forms are certainly legitimate: however, I argue that each of them on one level, and both on another level, suffer from shortcomings. The PHRETIH project appears to overlook the institutional imbalance determined by biomedical dominance, takes for granted the goodwill of modern personnel and reduces cooperation to a matter of relationship between the two types of professional practitioners. On the other hand, the DH project is too 'landlocked' at the village level, where it creates a false equivalence between healers and village health workers as a premise for equal cooperation; it refuses any form of integration

between doctors and healers until two conditions are fulfilled. But this clearly does not recognize the linkage that exists between these two processes: cooperation at the community level is closely connected to (and can encourage) cooperation between professionals of the two types.

The Tharaka programme has tried to surmount the shortcomings of the two Ghanaian projects by considering the two aspects of cooperation - the community level and the interprofessional level - as two inseparable dimensions of the same problem. Real collaboration could not be achieved without a process of professional development by the healers that tries to put them at the same level of the doctors; and this process must necessary be rooted in the community, being aimed at improving its health conditions, and based on and constructed from an already existing 'plurality of health care resources', whose actual relationship based on people's health-seeking behaviour tries to rationalize. The three forms this relationship can assume can be considered as the foundations of this 'jurisdiction-based' model of cooperation between all health care resources (Fig.9.2):

1) <u>exclusive jurisdiction</u>: when only a type of professional medicine (biomedical or indigenous) can be used for the management or prevention of an illness condition;
2) <u>complementary jurisdiction</u>: when both types of professional medicine are believed to be needed for complete healing of the same problem, but each one acting at a different level of causation;
3) <u>supplementary jurisdiction</u>: when both types of professional

medicine as well as forms of popular health care can offer treatment in competition and try to make up for the shortcomings of each others' treatment.

As we can see, this model includes not only the two professional sectors, but also the popular one, as a form of non-jurisdictional control of health care. The acknowledgement of the importance of these forms of family- and socially-based health care is fundamental for well-rooted cooperation at the community level.

In spite of their different shortcomings, the two Ghanaian projects also suffer from one other common fault: the belief that to set up a cooperation system through a training course for healers can be enough. Indeed, there are some typical organizational and planning aspects that cannot be overlooked if real cooperation is to be started. This is probably also the consequence of a common individualistic approach among traditional healers, who are considered as individual practitioners and not as professional groups or associations. In the Tharaka project, the stress is, as we have seen, on professional self-development through group formation as a premise for an effective and equal cooperation system. This includes the planning and organization of an effective referral system as a form of active interchange between the two professional systems, which remain autonomous and only loosely integrated. In the Tharaka model, the referral system has taken three main forms, which can readily overlap one another (Fig.9.2):

1) one-way referral, mainly in the case of an exclusive jurisdiction, where absolute control is claimed by a professional group over a certain sphere of competence (e.g. the Ugao for certain culture-bound syndromes such as kirumi or Urogi; or biomedicine for surgery and acute problems): in this case the patient is referred to the competent practitioner by the non-competent one;

2) two-way referral, mainly in the case of a complementary jurisdiction, when both type of practitioners claim a partial control over a certain problem, but at two different levels of causation (e.g. those either acute or chronic problems where both a somatic component of biomedical pertinence and a psycho-social component of indigenous pertinence are believed to coexist): in this case, referral takes the form of sending on the patient after the competent treatment has been performed;

3) multiple referral, mainly in the case of a supplementary jurisdiction, when both types of professional share a limited, loose type form of control over a problem which can also be dealt with by popular health care (e.g. those limited ailments for which pills, or herbal medicines or even home remedies can be taken): in this case the patient is referred to the other type of practitioner in case of failure of the treatment administered.

Even though these three forms were not always maintained for practical and cultural reasons (as the Tharaka follow-up evaluation shows), they are singled out to depict a system whose

Fig.9.2 Tharaka Jurisdiction-based Referral System

COMPETENT SPHERE OF INTERVENTION (JURISDICTION)	LEVEL OF CAUSATION INVOLVED	TYPE OF PROFESSIONAL RELATIONSHIP	TYPE OF REFERRAL SYSTEM
Biomedicine or Ugao	Natural or Unnatural	Exclusivity	One-way referral
Biomedicine and Ugao (herbalism) plus popular care	Natural only	Supplementarity	Multiple referral
Biomedicine and Ugao	Natural and unnatural	Complementarity	Two-way referral

ultimate rationality lies in the 'cognitive structure of illness' used by Tharaka people to direct their health-seeking behaviour towards what is believed to be the competent jurisdictional sphere. If these spheres are not always respected or simply overlap or are ignored either in people's behaviour or in the referral system, it is just because cultural, cognitive factors alone cannot fully explain the variety and fickleness of human behaviour.

FOOTNOTES TO CHAPTER 9

1) Special issues of the journal 'Social Science and Medicine' were particularly devoted to research and discussion on 'medical pluralism': Theoretical Foundations for the Comparative Study of Medical System (Edited by Leslie C.), 12B,2,1978; Parallel Medical Systems (Edited by Rubel A.), 13B,3, 1979; The Transcultural Perspective in Health and Illness (Edited by Weidman H.), 13B,2,1979; The Social History of Disease and Medicine in Africa (Edited by Janzen J. and Feierman,S.), 13B, 4,1979; Medical Pluralism (Edited by Leslie,C.), 14B,4, 1980.

2) An example of this is the range of twelve therapeutic options available in Kenya represented by Good (1987:61): even though it can be a useful preliminary tool to be used as a check-list to inquire about, e.g.,people's health-seeking behaviour, it is extremely poor if used to analyse the relationships between such options.

3) The concept of 'dominance' as used here, is similar to that proposed by Abbott (1988:109). Regarding the concept of 'professional dominance' used by Eliot Freidson, I share the opinion of Gerald Larkin (1983:190), who argues that Freidson is describing 'dominance' rather than analysing 'control'. The distinction is important to an understanding of the nature of dominance and the relationships between medical and paramedical or non-medical personnel: the latter two groups, even in a context of medical dominance can seek for an occupational monopoly in their sphere of competence (what I have termed 'jurisdiction').

4) See the special issue of 'Social Science and Medicine' on Utilization of Indigenous Healers in National Health Systems, 16, 21, 1982.

5) An example of a failed attempt at 'incorporation' is that of India (Jeffery,1982).

6) Experiments in Trascultural Psychiatry were particularly carried out in Western Africa (Lambo, 1978).

7) A useful series of recommendations for the proper 'articulation' of Western and traditional systems of health care at the national, regional and village level is proposed by Carol MacCormack (1986:161).

8) This is the locution I would prefer instead of 'medical pluralism'.

9) I developed the 'role-analysis approach' as a practical tecnique for setting training priorities on the basis of the

'task analysis' proposed by Carol MacCormack (1986:156-7):it is fully described in Appendix L.

10)The Primary Health Training for Indigenous Healers (PRHETIH) Programme developed since 1979 in Techiman District by the local Catholic Holy Family Hospital in collaboration with the Ministry of Health, the Centre for Scientific Research into Plants Medicines and the Ghana Psychic and Traditional Healers Association is undoubtely one of the most interesting and successful professionally-focused experiments in Africa. It grew up of a series of relationships 'nurtured over the years by staff members who attended the festivals of the healers and by healers who came to the hospital for conditions that they could not manage themselves' (Warren et al.,1982:1876).This experience, along with the participation of the hospital in a Primary Health Care joint programme with WHO and Ghana government which included an integrated approach to the training of TBAs and VHWs, convinced hospital personnel of the need of a multidisciplinary project involving THs, too. After a first, well-attended public meeting (reported on radio and television) with indigenous and biomedical practitioners, a training course was planned and a Coordinating Committee composed of 16 members of both types of practitioners was set up to oversee the project, while a small planning group composed of project workers defined the course objectives and contents. Prior to its implementation, a survey was conducted in the area using a questionnaire: over a period of six months it identified and interviewed 45 healers and 7 apprentices in the urban township of Techiman. The survey was designed to explore healers' knowledge and work, and their attitude to participation in the proposed training programme. The survey findings reduced the original 31-week training programme to two shorter 7-week cycles and led to the decision to include traditional topics in the syllabus at the healers' request, whereas the original plan to instruct them in the use of four or five basic allopathic medicines was abandoned because of their scarcity in Ghana. The topics in the pilot training programme, run by eleven different trainers from the hospital staff, district-level Ministry of Health workers and programme field coordinators, included: hygienic preparation, preservation and storage of medicinal herbs, diarrhoea, malaria, convulsions, basic first aid, measles, jaundice and leprosy, family planning, weaning foods, vaccination and basic nutrition. From the healers' responses to a follow-up questionnaire, it was clear that the most popular sessions them were those dealing with herbal practices, followed by those where a particular health technique or medical treatment was taught; of least interest were advisory or descriptive sessions on preventive measures and sanitation. Teaching methods used a question and answer format, the demonstration/return method, visual aids and drama.The healers were asked to make a contribution to meet the cost of training costs. A personal follow-up visit was done to each participant after every weekly

session in order to test their understanding and retention of what was taught: a task that required a great deal of patience, time and sensitivity.
After the first two pilot groups of seven people each, the programme was further extended to other groups of healers with the support of Techiman District Council. Follow-up visits using a standardize questionnaire revealed that the trainees had retained over 60% of the teaching; a further 6-month follow-up survey was then conducted primarily on behavioural changes. An herbal arboretum was established with the support of the Rural Health Training School.
The Dormaa Healer Project (DHP), sponsored by the Presbyterian Church of Ghana started in 1985 with a nine-months pilot training programme with fifteen healers and two VHWs from five villages; and, after a positive evaluation, it has gradually been extended since 1986 to cover the whole district with a five-months training course with classes of 12-15 participants (herbalists,priest-healers,village health workers) held in the villages. The main goals of the programme are the mobilization of all medical resources in rural areas by dialogue and cooperation at the village level among traditional healers themselves and between them and modern health personnel, with the elimination of prejudices on both sides; and the professionalization of healers, by introducing them to the essentials of modern medicine and the improvement of their medical practices. In tab.9.1 in the text the topics treated during the six course sessions are outlined.
Project staff was composed of the director (a Dutch anthropologist), an assistant and a group of part-time teachers composed of doctor, nurse, agricultural advisor, health inspector, home science teacher and priest-healer. Training was conducted through seminars and workshops for them on specific subjects such as the integration of traditional medicine in Primary Health Care (PHC), and teaching literacy through adult education. The project assistant and the priest-healer also attended a three-months course on medicinal plants at the Centre for Scientific Research into Plant Medicine. The curricula for each section were jointly designed by the project staff and standardized questionnaires developed for each session to check partipants' retention. The results of such tests were used for revision and refresher courses for former participants. In tab.9.2 in the text, indicators of effectiveness as used for the final evaluation of the Dorma Healer Pilot Project are presented: no figure is given by the author (the research director) about their results.
The involvement of the local community played an important role in this project: before any course started, the support of the villages was ensured by meetings with healers, members of the traditional village council, health committees and representatives of churches and political parties. The community was encouraged to support the healers financially during training and fund-raising activities were organized in the villages to pay for the healers' transport

and teachers' food. In each of the villages involved, a healer was elected onto the local health committee, some members of which were also occasionally invited to attend classes to guarantee openness.
A peculiar feature of the project was the joint participation of healers and VHWs in the course: this helped to develop a change of attitude and group solidarity, after the initial reservations on the part of the VHWs: they began to feel and share a common responsibility for the health situation and needs of their villages, seeking ways and means to improve it. It is significant that the healers greatly outperformed the VHWs in the end-results,as the project director reports: 'In the tests, expecially at the end of the section on diseases, the results of the village health workers were far behind those of the healers. This is surprising since they had already attended a number of courses on the diagnosis and treatment of the most common diseases during their training as village health workers' (Fink,cit.:334).
Moreover, an important step in the direction of a professional development of healers at the village level was the opening of a cooperative store to produce plant-medicines and plant-protein concentrate for selling.
Finally, each healer who successfully attended the course received a certificate which entitled the owner to an annual license, regardless of membership in one of the two existing healers' association.

CH.10 NEW FORMS OF LEGITIMACY FOR AN OLD JURISDICTION

10.1 The Myth of Origin of the 'Ugao'

There is a popular myth in Tharaka which I collected from an old mugao, who told me it was once taught to young boys by their grandfathers during evenings in front of the fireplace (riku) while waiting for food:

> 'Ugao originated from Mbwa. The clan of Nyaga was born with Ugao. We were born on the skin of nkurungu (antelope). Our forefathers came from Mbwa holding roots and horns. They trekked from Mbwa and on the way they taught people how to prepare mithega (medicines) so that they could not be eaten by wild animals like hyenas and lions.
> When they arrived, they showed others who claimed to be agao how to prepare mithega using a goat. Because the Nyaga clan was poor, it had to teach other clans about Ugao to get some goats and food.' (M'Muriki Mirigaru, Nyaga clan, Kirini, 16-11-1985).

It is clearly a foundation myth, concerning the origin of the Tharaka Ugao. But the question is: why did the Ugao need a founding myth? There is no myth of foundation for agriculture, breeding, or even for blacksmiths in Tharaka. Therefore: why only the Ugao ?

To answer this question, we need to consider what Leach terms 'the role of myth in the expression of social contradictions' in his Political Systems of Higland Burma (Leach, 1954: 256). Leach is just developing some ideas already contained in one of Malinowski's early writings - Myth in Primitive Psychology - where Malinowski seems to go beyond a non-conflictual view of society by considering the opportunities the myth offers (and particularly, in its different versions) for

justifying situations of inequality in rank or power among different groups or situations of radical social change (Malinowski,1926). In this respect, he proposes to reject all the explicative and symbolic interpretations of myths of origins. The characters and creatures we find there are just what they are - he says - and not symbols of concealed realities. As regards the explicative function of these myths, they do not conceal any problem, they do not satisfy any curiosity, they do not contain any theory. If 'the reality of the myth lies in its social function', it becomes necessary to look at its social context in order to understand the meaning of any myth of origin. And this is exactly what I shall try to do.

What is the social context of the myth of Ugao if not that of a society traditionally based on a segmentary lineage system? According to Durkheim, the forefather of the concept of 'segmentary society' (Durkheim, 1893), the dominant principle of this kind of social organization is the equality of segments, organized from top to bottom to form a single, embracing genealogical scheme. Each segment (clan, lineage or family) is regarded as an autonomous unity, related to the others according to lines of sociability or opposability that follow from common descent. In this context what could be the meaning of talking about Ugao belonging to a certain clan - Nyaga - who were born with it?

I can suggest two possibile interpretations of this: the first one is literal, the second analogic. Literally speaking, the myth tells us that the art of healing is traditionally owned in Tharaka by a single clan who transmitted it by inheritance.

Only later did this clan start exchanging this art for goods from other clans, being too poor to maintain itself. I indeed found that Nyaga clan was the most common among the agao I met and interviewed (7 out of 45). We can also remind ourselves that in the myth of the exodus from Mbwa there is the reference to a triadic classification of the clanship system (discussed in the previous chapter): and that the red clans could be associated with the Ugao art.

To argue by analogy, the crucial point in the myth is the kind of language used. The language of kinship is a language of exclusiveness: it creates a group identity, socially defined and distinct from any other. Individuals who want to conceive of themselves as belonging to enduring groups will express this strong identity of theirs through the language of kinship (Leach, 1982: 143). Therefore, the Ugao is something whose property is exclusive to a certain social group, and is reserved to certain people whose identity vis a vis to others is based on it. The secret of this exclusive ownership becomes the logical consequence of this. There is no secret in agriculture because there is no exclusive ownership of cultivation knowledge by a special group. The skin of the antelope (the animal whose horns are used by the agao), the roots and the horns themselves become the marks symbolizing this exclusivity.

Whichever interpretation we choose, if we examine the myth in its social context, we can discover its probable social function: to express the typical segmentary society's contradiction between its equality principle and the existence of

a particular professional group based on an embryonic form of division of labour. It is well known that a segmentary society tends to inhibit the emergence of any form of leadership and inequality - in whatever social, economic, or political form. How then to justify the existence of a group whose identity and work tend to be different from that of other people, and the probable conflicts this would give rise to ?

Firstly, there is the mythological justification: the reference to Mbwa and the related myth of origin of the Tharaka people. By connecting the Ugao with that, the intention is undoubtly of giving lustre, a special quality, to a certain state of things: saying that 'Ugao came from Mbwa' implies that the origin of the Ugao jurisdiction is as ancient as the Tharaka people. The attempt to express and reinforce the social prestige of the Ugao in the community is evident in a society based on an oral tradition. Secondly, the myth contains an indication of how to integrate this professional group by means of an economic exchange in the context of an egalitarian segmentary society. Medicines are prepared and knowledge is taught in exchange for goods and food. The fundamental reciprocity of this exchange is evident: it compensates in some way for the asymmetric relationship - in terms of knowledge and power - that lies beneath such economic exchange.

Another version of the same myth which I collected in Kibuka from mugao Mugambi is even more explicit in fostering this interpretation, adding more elements to support it: it connects the origin of Ugao with Kibuka, a founding hero and first mugao of Tharaka people; he belonged to the Nyaga clan, and used his

powerful horns to protect his people from the invaders.

> 'Ugao belongs to Nyaga clan, to the lineage (riiko) of Karukundi. To this lineage of Karukundi belonged Kibuka, the first mugao of Tharaka, who came from heaven during a very heavy rain as a baby. Kibuka first settled in Tunyai area, at a place now named Kibuka: when there, he helped Tharaka people in fighting against their enemies by giving them a medicine to keep them alive after death. He put a horn in his son's stomach, when setting out for the battle, to make him immortal. So there came a time when people argued about this: they revealed the secret of Kibuka's son.So when he was killed the horn was removed and he did not come to life again. When informed about his son's death, Kibuka became very annoyed with the people and migrated to Tana river at a place still named 'Kibuka's falls', where he is said to be settled inside the water. Since then Tharaka people were being killed without Kibuka's help. From that time Nyaga people of Karukundi inherited Ugao and started teaching it to other clans' (Mugambi Mwarania, Nyaga clan, Kibuka, 26-11-1985; synthetic version by Joseph Chabari Mugao, research assistant).

This second version of the myth of Ugao clearly seems to point to the difficult relationship between the mugao and the common people since the beginning of this art: in spite of his intention of helping people by his horn against the enemies, the probable envy of his own people destroys this power. Kibuka is the prototype of the mugao and of his power: a power arising from his knowledge. People's attitude towards this denotes the existence of a potential source of conflict, implicit in such power. The ambivalence of this power - its possible use either for doing evil or good - is probably at the origin of people's 'ambigous attitude' of envy and fear simultaneously.

To sum up, we can interpret the myth of origin of the Ugao as the constitutional charter of its jurisdiction. Its social function is to delimit in the mind of the people a reserved territory for the exclusive ownership of the Ugao. Those who do not know it cannot enter there: unless they exchange other social

goods for this type of knowledge and submit themselves to a process of apprenticeship. In this respect, we can consider the myth I collected as the official 'ideology' of the Ugao in Tharaka society. Like any foundation myth, it is never fair, impartial, unbiased, since it is created ad hoc to justify a certain situation, to give a rationale for the imbalance in terms of knowledge and power, prestige and richness - that is, in terms of status - arising from it. Where there is a situation of inequality, the myth has the fundamental function of relieving the social strain arising from it, especially in a segmentary society based on the principle of equality. A jurisdiction - and thus a profession - necessariliy implies a situation of inequality of knowledge between the 'expert' and the lay public.

10.2 Individual License and Group Recognition

If the myth of origin of Ugao we have analyzed represents the 'constitutional charter' and the official 'ideology' of the Ugao jurisdiction, its function is mainly to legitimate its role in Tharaka community, with particular regard to the social strain this role produces in terms of social status arising in an egalitarian society. In doing so, the myth ensures people's acceptance of such role, of the cultural jurisdiction it represents, and of the 'medical' functions it plays, thus warranting compliance, 'uncoerced obedience' (Weber,1947:324-45) to the Ugao's practitioners. As Carol MacCormack puts it,

'People invest legitimacy in the healers to whom they turn,

> whether they are scientifically trained physicians in state or private bureaucracies or traditional practitioners. In seeking legitimacy in healers, people reassure themselves that the system of healing has meaning and they can undertake the quest for health with conviction' (MacCormack, 1981:424).

How can we consider this type of legitimation? Following again MacCormack use of Max Weber's classic typology of legitimacy (rational-legal, traditional and charismatic), we can define the type of legitimation the myth of Ugao produces as 'traditional legitimacy'. This is a form of rationality typical of small-scale rural societies, and developed over a long period of time, during which special personal qualities become associated with a certain corporate group, such as particular curative skills in the case of the Ugao practitioners. The main feature of this type of legitimacy lies in its being well-rooted in the 'time of origin', of which the myth becomes the cultural expression:

> 'In the African context, traditional legitimacy is often associated with the wisdom of ancestral time. 'Uncoerced obedience' arises from personal loyalty to those recognized as the heirs and the bearers of legitimacy' (ibid.:425).

The question I wish to raise at this point is: 'Is this kind of traditional legitimacy still sufficient for the Ugao jurisdiction in the present day?' MacCormack suggests a positive answer, when she closely associates 'traditional' medicine with 'traditional' legitimacy (ibid.): my personal experience within the Tharaka community and Kenya society as a whole suggests a different answer. Nowadays, the Tharaka community is undergoing a process of rapid social change (see 1.6) that makes it an ever less homogeneous social entity. Stratification based on sex and age in pre-colonial times has given way to new forms of

internally diverse status based on levels of education, wealth, housing, occupation, produced by an increasing division of labour with a consequent specialization of function. As the social context becomes less homogeneous, the culture needs to replace the ancient community with new divisions, in order to justify recently acquired statuses.

It is evident that this cannot be irrelevant to the shaping of Tharaka attitudes towards the Ugao. To use modern biomedicine is in many cases seen as an hallmark of 'development' and 'modernity'; the resort to indigenous medicine becomes labeled in public as 'backward behaviour'. The role played by external cultural agencies in developing this negative public attitude towards traditional medicine has been fundamental: school teachers, missionaries, priests, government officials and mass media (especially the radio, so common even in the most remote areas) were the main agents of this process. Through them, the Tharaka community has steadily become fully part of a national and an international context, with its rules, laws and policies. This has transformed Tharaka from being a closed community into being simply a part of the wider social system.

In this context, to think that the local 'community' is still the main force shaping people's attitudes towards indigenous medicine (and thus its legitimacy) appears at best naive, if not totally unrealistic. The new equation 'traditional medicine=backwardness' has become common sense; if we do not adequately take this into account, any discussion of legitimation would be flawed.

But, one knows, public attitudes do not always correspond to actual private behaviour: so too in Tharaka, where the majority of the people have continued to attend Ugao sessions when affected by a problem they believe falls within the mugao's jurisdiction. Even most followers of the various Christian denominations (they are a great part of the total population, nowadays) have continued to do so; but they do so 'at night', as some agao suggested me maliciously. Therefore, we could say that the Ugao jurisdiction has continued to enjoy a sort of semi-illegal kind of traditional legitimacy, thanks to this discrepancy between the public and private attitudes of people.

However, this was just a starting-point: when the agao began their self-development process by joining together in small groups for collaborating with modern health care personnel, they soon realized that a new kind of legitimacy was necessary. Their semi-illegal condition was acceptable to the extent that it was consistent with a professional statute of the individualistic and competitive type we have analysed earlier (see 8.5): when they decided to move towards a new type of statute, the need for a new kind of legitimacy which would allow for full legal recognition both at the individual and collective professional level, appeared evident. It was time to fill the gap existing between an existing traditional legitimacy and a new modern, rational-legal legitimacy (1).

The new forms of this modern legitimacy were soon singled out by the agao: the license in legal recognition of healers as individuals; and some form of registration of their groups as organized bodies so that their meeting might be recognized as

professional. The two problems were strictly interconnected. I still remember the fear that most of the agao explicitly expressed during their first meetings as groups because they did not hold any license: they were scared of being prosecuted for what they were doing. And their concern, often expressed, that the authorities were being informed and gave full support to what was taking place during such meetings. The fact that the Division Officer, Chief, Subchiefs, Kanu leaders, and other government officials attended some of their meetings allowed them to overcome their initial worries. But even after that, every time an important decision had to be taken (e.g., moving their meeting place, building their gaaru,etc.) the full support of the local authorities was always sought.

The history of the agao's struggle for getting their 'place in the sun' in the world of rational-legal legitimacy falls into three phases, each corresponding to the implementation of a different strategy. The first phase lasted about six months, covering the first half of 1986. During this period, the main issues - the group's recognition by government and the acquisition of individual licenses - were pursued by what we could term a 'local strategy'. Since a collective license could be issued by the County Council of Meru once a group had been formarly registered as a 'self-development group' at the district office of the Ministry of Culture and Social Services, the agao groups of Kibuka and Kithino (the only two which were fully constituted at the time) first tried to follow this route. Each member contributed 10 KShs. for registration fees; the

Assistant Chief of Tunyai and the Community Development Assistant (CDA) of Chakariga fully supported their application. The latter pre-registered the two groups at his divisional office on May, 25th 1986 under the category of 'muthethia groups' (helpers groups), making an exception to the normal regulations which required as condition for registration a membership of between 25-40 and literate officials (chairman, secretary and treasury), on the ground that the groups were of a special character. Then, both these government officials attended the first public meetings held by the two groups independently at Tunyai market on June, 13th 1986; at these meetings the two newly pre-registered groups were introduced to the general public with the full support of the authorities. It was a first, important step for the agao towards changing public opinion and people's attitudes. The Subchief's speech touched on the most sensitive issues in people's minds: he said that what was taking place was known to the government through its local officials, and thereby nobody should be afraid. He assured the audience that the groups were composed by agao and not by arogi: he said he would intervene if he learnt that a murogi had joined one of the groups. In addition, he stressed the developmental character of the two self-help groups, and the importance of their new cooperation with Nkubu hospital. The CDA, on the other side, emphasized the agao's knowledge of medicinal plants, and the importance of working in a group which was officially registered, with elected officials and defined internal regulations. This would allow them the opportunity to forward their requests to the Divisional Development Committee (DDC). After the chairman of the Kithino

group (at the time still Njoeli Muchiri) had stressed secrecy as an essential feature of the Ugao, the CDA promised he would have reveal to outsiders any group's secrets. It is also extremely interesting to report that, when the Subchief suggested the two groups fuse in order to make up the numbers required for registration, the agao responded by saying that this would bring about a lot of trouble: the agao would start to fight among themselves, killing one another.

The initial success of this strategy was quickly cut short. When the chairmen of the two groups went to Meru town along with the Subchief to complete their registration with the district Community Development Officer (CDO), he refused to register them, since they did not fully satisfy all the condition for 'self-development groups'; instead he suggested, given the aims of the groups, that they join the national association of hearbalists which was in process of being formed at the time.

The groups' failure with this initial local strategy paralled failure at the individual level too: after the successful pre-registration, the Chief of South Tharaka had promised to issue individual licenses to each group member. However the agao soon realized that such a document (for which a heavy fee was charged!) had only a very limited temporal and spatial value, since it had to be renewed (and paid for) every year, and it was recognised only within the territory under the Chief's jurisdiction (i.e., South Tharaka Location).

This led to the groups' second phase, characterized as their 'national strategy' that lasted from the second half of 1986

until 1992. The chairmen of the two groups met with Araigua Stanley, a self-taught herbalist from Kianjai (Tigania) who was in charge of the Eastern Province branch of the '_Mugano wa Waganga wa Miti Shamba_' (Association of Herbalists), a national body which was still in the making. During their meeting in the the latter's office in Meru, they were introduced to the aims and regulations of the association; and when they discussed about their eventually joining it, they were asked for a fee of KShs. 1,000! This definitely discouraged the _agao_, who seriously felt they might be exploited. Moreover, they were afraid of having their 'secrets' stolen; and their comment on what they had seen in the herbalist's office was that 'We have horns, not simply herbs!'. In any case, they agreed to discuss the matter with their respective groups before taking any final decision. When the issue was reported back, the two groups decided to drop the idea, partly because of the exorbitant fee asked, and partly because they did not wholly trust the person in charge of the association. Some years later, I learnt that the man had just been appointed there by the KEMRI director of the Traditional Medicine Unit, with whom he closely collaborated, and that the association was simply used by him as a means for extracting medicinal plants from healers.

Though the second strategy failed at a collective level, it proved more successful in benefitting the _agao_ as individuals. The two consultants to the Tharaka project were informed that the Ministry of Health headquarters were willing to recognize the Tharaka healers if they presented their particulars to the relevant officer at Afya House. The ID card numbers and the

information requested were collected from all the groups'members (they were now four, since the Kamarandi and Kamanyaki groups had been recently constituted) and submitted as requested to the Ministry in Nairobi through the assistance of Dr.Nyamwaya and Mrs.Kimani. After a few months, in May 1987 the Ministry issued certificates of 'Practice of Herbal Medicine' to 32 practitioners that allowed them to exercise all over the country 'according to the general accepted African norms in such practice and provided further that the material used in such practice shall have been known not to be toxic in the usual portions recommended or administered in the form of injection' (Appendix H). The certificates were officially issued to each mugao at a second public meeting of the four groups held in Chiakariga on June 22nd, 1987 with the participation of the Division Officer, the MP for Tharaka, all the Kanu leaders, and the Chief of South Tharaka; the latter introduced each agao group to the large crowd which was there for market day, and displayed the certificates issued by the Government of Kenya. It is important to mention one significant incident that happened on this occasion. The Kanu chairman of Tunyai began to speak and accused the agao of witchcraft (he was a follower of the Seventh Day Adventist Church which strongly opposed traditional medicine): in replay, all the agao stood up and showed off their certificates. The explicit support of the Kanu chairman of the whole Tharaka Division, who praised the agao as 'progressive people' following the right path for the development of local medicine and for the progress of their community, definitely silenced opposition.

In the next five years, as a consequence of all this, the number of agao in the groups doubled; two new groups (Muthitwa and Rwakiemb'ea) were formed, and some others in Central Tharaka are still in the making. The prospect of getting a certificate attracted all these practitioners out from their undercover practice. Unfortunately, the policy of the Ministry of Health changed during this period: after a short period of informal recognition, the government went back to their previous practice of disregarding healers. This has caused a lot of trouble within the agao groups (see Chapter Eight): it created a division between 'A-grade' licensed members, and 'B-grade' members who still waited their license, and discouraged attendance by most of the latter who felt cheated.

The shift in the government policy suggested a third type of strategy which we could term 'autonomous'. This third phase started in 1992, so recently that little can be said about its success or failure as yet. Since both local- and national-level strategies have at least partially failed in their aim to ensure that all the agao got individual licences, a new suggestion from AMREF was to use them, as an African NGO, to issue a certificate jointly with the local district Medical Officer of Health after AMREF had given the agao a short course in Primary Health Care. The groups are now waiting for the implementation of this new offer.

As for other main issue, the formal recognition of the groups, the failure of the local strategy to be registered as 'self-development groups' and the inappropriateness of links to the national association of herbalists, has meant trying a new

'autonomous'strategy. The new idea is that, after eight years, it it is now time to try to establish some formal ties between the steadily growing groups so as to form an association at the district level (in 1992 Tharaka and Chuka Divisions were split off from Meru District to form the new Nithi-Tharaka District). Once fully constituted, this association could represent a high profile 'pressure group', both at the local and the national level, in order to gain at last full legal recognition.

The problems, though, are many. First, there is the serious problem of inter-agao relationships: I have already explained at length the reasons for the giciaro (see 8.2) overcoming problems of rivalry and fighting within the groups; I also already mentioned the fierce response of the agao to the Subchief's invitation to fuse the groups during their first public meeting in Tunyai. When a doctor at Nkubu Hospital (who was not aware of the problem) tried to call a meeting of all the four groups at Kamathuri, the meeting place of Kithino group, on June 14th, 1989, it failed miserably because nobody attended it (not even the hosts!). When questioned why, initially the agao gave a series of untrue but polite reasons: it was too far away, they were too old to walk there, the farthest people had to spend a night in the open, and so on. However, after deeper probing, the real reasons came out: they did not like 'to go into other people's homes' and 'there was also no purification ritual' (Kamarandi group); their lack of confidence and their fear of meeting all together came from the fact that 'they did not like the idea of all the agao coming to their centre without any

ritual being performed or any oath being taken which would bind them together and avoid any mutual fear and suspicion' (Kithino group).

Besides these internal problems of relationships, some practical and organizational problems make it almost impossible to weld a single association out of the existing groups: the need for a central office, for managing public relations at a higher level (D.O., MP.etc.), the distances to travel for some groups, the needs to elect central officials, etc.. However, all these diffculties do not appear insurmountable, and maybe in the future the agao will find their way to overcome them.

10.3 Three Judicial Cases

How far has the struggle of the agao groups for both an individual and a collective legitimacy influenced public attitudes towards them? To what extent has the common-sense equation 'Ugao=backwardness' been modified? In spite of the difficulties of the partial success achieved, it is my impression (supported by what I found during the follow-up study in 1992) that a real change of attitude is actually taking place among both the general public and the local community leaders and authorities. The agao who got the government's certificates told me that patients now have much more confidence openly to come to them, and they themselves can travel both inside and outside Tharaka without being harassed anymore, once they show their licenses. Regarding the attitudes of the 'opinion leaders' and of

the local authorities, I wish to examine three judicial cases I consider particularly significant, followed by the opinions I collected from some of the most prominent church leaders in the community.

THE CASE OF M'KABORO NJUME

M'Kaboro is an old member of Kibuka group who, in December 1986, had to face a serious family problem: one of his sons-in-law had a love affair with his second wife. He informed the woman that he was aware of it: she reacted by going to the local authority (headman) and saying that her husband wanted to bewitch her. Then the headman sent some young KANU members to M'Kaboro's home to confiscate his kiondo (basket). Once the kiondo was confiscated, the mugao tried without success to get it back through the authority of the Chief of Mitunguu (under whose jurisdiction he lived). Then he reported the issue to the Kibuka group which, after a discussion of the case, decided to write a letter to the Chief of Chakariga (who knew them) asking for the release of the kiondo through his good offices. After that, the Chief wrote a letter to his colleague in Mitunguu requesting the release and explaining that the person in question was a good mugao (and not a murogi) and a member of a recognized group. Finally, the kiondo was released by the headman on the orders of the Chief of Mitunguu.

THE CASE OF M'RUGIA MUTHURWA

The second case happened in August 1987 and involved another member of Kibuka group, M'Rugia Muthurwa. His young son had injured a neighbour of his with a panga (a big knife) during a quarrel, cutting his hand. The wounder was pursued by the headman and the administration police of Mitunguu but he was not found: after two weeks of fruitless search, they decided to raid the father's homestead hoping to find him there. When they did not, in retaliation they arrested the father on the allegation of him being a 'witch', and confiscated his kiondo and his government certificate (after he had in vain tried to show it). He spent a night in jail at Nkubu police station, where he had been brought. The following day, he was taken to Court: he was released on bail of KShs 1,000 and told to appear in Court again for judgement the following month. The indictment was 'charged with being in possession of charms contrary to Act 5, cap.67' (Witchcraft Ordinance).

When the issue was reported to the Kibuka group, they discussed the problem of the confiscated licence without which the mugao had no evidence to show in court to defend himself from the witchcraft allegations: they decided to inform the doctors of

Nkubu Hospital, asking for their support. The group considered the matter very seriously, and the chairman wanted to take the headman who had confiscated the licence to Court because he had done so by force with no right to do so. They decided to wait until the case against their member would be over.

When the Public Health Doctor in Nkubu was informed, he promised his full assistance and produced a copy of the mugao's certificate which he kept in his office. He also wanted to meet personally the police officers who had arrested the mugao to hear directly from them what had happened. Once he realized the groundlessness of the allegations, he decided to go himself to Court to meet the Court prosecutor in order to clarify the case. He prepared a written statement which he submitted together with the copy of the license: in the statement, he quoted the national guidelines of the Kenya government regarding the inclusion of traditional healers in community-based health care programmes, and summarized what the Hospital had doing with them in Tharaka since 1985. The Court prosecutor accepted the statement and, after after further explanations over the names and the uses of the objects contained in the mugao's bag, closed the case. When the mugao was definitely free, the Kibuka group decided not to take the headman to the Court to avoid more trouble, at the doctor's suggestion. Instead, they called for a meeting with the headman to settle the matter by discussion. The headman came to their place and was informed in detail about the purposes of the group. He was very apologetic and made his apologies for what had happened to their member.

THE CASE OF KIGANKA KUNYIRA

The last case involved a member of Muthitwa group, Kiganka Kunyira, who in September 1990 was arrested on the allegation of witchcraft by the brother, with whom he had quarreled. After being jailed in Chiakariga prison, the man was brutally beaten by police (a common practice). His certificate and kiondo were also confiscated.When the leader of Muthitwa group informed the others about what had happened to one of their members, they decided to go to the Chief of South Tharaka personally to take up the mugao's case. The Chief accepted their defence of the group member and ordered the police to release the man after he had sworn an oath of 'good behaviour' in front of him and of the other group members.

These three judicial cases have two common elements that show how important is legal recognition nowadays even in a community like Tharaka - namely, the licence and the agao group. In all three cases, these two played a key role in protecting the healers from the arbitrary and oppressive behaviour of the local

authorities and of the police towards them. A single mugao alone with no license to show would have had no chance in all the three cases. It is not fortuitous that the authorities were concerned to confiscate the mugao's certificate in order to remove evidence to defend himself with in court. The collective support of the group as a recognized social entity also played a fundamental role when confronting the authorities: who started to respect the agao, even apologizing for their mistakes (as in the case of the headman).

The third element is specific to the case of M'Rugia Muthurwa, and is represented by the influential role that an external agent like a doctor, can play in legitimating the agao's activities. The statement the Public Health Doctor gave in Nkubu Court was crucial for the release of the unjustly charged mugao. Without his support, the mugao would probably have been condemned, without having any proof to exhibit. The Witchcraft Act, even though seldom applied, is still in force in Kenya.

That, in spite of many setbacks, the attitude of the public authorities and leaders towards the agao is little by little changing is also demonstrated by the changing attitude of the local churches. Their role is fundamental in determining the attitudes and opinions of their members nowadays: and during the informal interviews I had with the leaders of the main Christian denominations which are present in Tharaka, I could perceive a certain degree of cultural plasticity unthinkable until recently. The pastor Nyaga Kagembo of Pentecostal Church, traditionally one of the most opposed to any form of traditional medicine, stated

he had no prejudice against it, provided its practitioners are adequately trained workers practising herbalism. Muthengi Mwarania, pastor of the African Inland Church, expressed an extremely flexible and open attitude towards the Ugao; he recognized that it is often utilized by many members of his church (he is himself a mugao's son!). This syncretic African church is probably the most pliable towards any traditional cultural element and maybe in future will be a potential source of charismatic-type healing cults. Ibrahim Kabuku, pastor of the Methodist Church, said he appreciated the opportunities offered by the herbal medicine for certain diseases, but he condemned as a'superstitious practice' the use of horns. Finally, Father Orazio Mazzucchi of the Catholic Mission at Materi, who from the beginning had been sceptical towards the Tharaka project in spite of the fact that the Italian NGO C.U.A.M.M. had a Catholic background, declared his appreciation of the (limited) benefits offered by traditional medicine, and the role it can play in collaboration with the modern medicine.

That these statements by church leaders show a greater degree of cultural plasticity than in the recent past (probably because of the shifts in the local and national situation) is an hypothesis that needs more work if it is to be proved: in any case, it is a matter of fact that all the pastors and priests, when questioned about their congregation'behaviour towards traditional medicine and what sanction they might take against someone using it, answered that they recognized the existence of the problem and admitted it was unlikely they would apply actual sanctions. The previously hidden 'cognitive dissonance' between

public and private attitudes has probably started to come into the open and become a matter of discussion. That open public condemnation is no longer either easily expressed or accepted by Christian church members is an already extremely significant cultural change. Even though acknowledgment of the traditional medicine's positive value is still mostly limited to its herbal component, it is already a significant step beyond dogmatic condemnations and simple preconceptions.

10.4 National Policy Options and the Kenyan Case

A purely traditional form of legitimation is clearly insufficient even in a rural community like the Tharaka one. The Tharaka case proves how far the modernization process has gone, reaching with its influence even the most isolated inland communities. A social stratification based on division of labour, cultural divisions usually expressed through the language of religion, the community's marginality within a national social system dominated by the highlands townships - these are all elements in a process of change now taking place.

In this new, changing context, what role is there for an old jurisdiction such as that of Tharaka Ugao ? Undoubtely, if it wants not just simply to survive (perhaps, in a kind of 'reserve'), but to compete successfully with the new professional jurisdictions that the growing division of labour has produced especially in the medical field, it must struggle for full rational-legal legitimacy. This does not mean that it should lose

its traditional roots within its original community: success hinges on the ability to find out some form of integration between its traditional background and the new legal regulations required by the national state. This poses a serious theoretical problem: in Weber's classic typology, the two forms of legitimacy (traditional and rational-legal) are considered antithetical: they are the result of two different historical processes, which we could epitomize in the terms 'community' and 'society'. Can they be theoretically and practically reconciled within the same historical reality ?

I wish to end this chapter by putting forward an hypothesis, and then examine under what conditions it might be realized. I argue that the full legitimation of a professionally developed traditional medicine (which maintains its own distinctive features) can only result from a dialectic process between a bottom-up form of traditional legitimacy and a top-down form of rational-legal legitimacy working within the community (2). My hypothesis is based on two postulates: firstly, that a purely traditional form of legitimacy is absolutely insufficient for the present time (because of the various social and cultural processess working in the community which I mentioned) and,in any case, that would confine indigenous medicine to a sort of archaic 'medical reserve'; secondly, that the exclusive search for a purely rational-legal type of legitimacy in turn would be totally self-defeating, since it would deprive indigenous medicine of its most positive features, namely the holistic approach and its integration into the local social and cultural environment. Therefore, I wish to argue that a dynamics of interaction

between a traditional legitimacy rooted in the local community and a new rational-legal form of legitimacy is the only way that can ensure a real professional development for the future of African indigenous medicine. This hypothesis, based on my personal experience in the field since 1984, needs two main conditions to come true: the first is structural, the second is cultural. I shall examine both in detail.

The first condition regards the policy options concerning the role of traditional medical practitioners in a National Health Care service: what is the best option which an African national government could choose if it is to guarantee the structural framework within which a traditional healing jurisdiction such as the Tharaka Ugao could properly work with full legal legitimacy? A brief literature review could first help to single out what is the meaning and the legal, economic and cultural implications of each different choice (3).

One of the earliest (and still valid) typologies of policy options is that proposed by Kikhela, Bibeau and Corin (4). A second typology of choices has been proposed by Barbara Pillsbury (1982) in a slightly modified version (5). A further typology is proposed by Jan Stepan in his essay on existing patterns of legislation concerning traditional medicine in both developed and developing countries (6). Finally, Freeman and Motsei (1992) provides a rather similar synthetic version of the most positive possible options (7). The existing literature, in spite of some slight differences and a diverse degree of details, is thus in agreement in sketching the possible options.

There are first the negative or 'neutral' options: banning indigenous medicine, ignoring it, or allowing tacit, informal recognition. The latter is the option adopted by Kenya Government in recent years: in absence of any legislative recognition, the Sixth National Development Plan stated that:

> 'Although for a long time the role of traditional medicine and its potential contribution to health has been viewed with scepticism, a large proportion of people in Kenya still depend on it for cure... During the plan period, Government will encourage the formation of professional associations for traditional medicine practitioners. Such associations will facilitate the gathering of necessary information for the use, development and appropriate adaptation of traditional diagnostic, therapeutic and rehabilitative control technologies that will become part and parcel of formal medicine research' (Republic of Kenya,1989:229).

While this option goes a step beyond non-recognition, it still does not commit the official authorities to any formal recognition. However, this option can allow for a certain degree of experimentation and involvement of indigenous health workers in specific primary health care activities, as the 'National Guidelines' issued by the Kenyan Ministry of Health show:

> 'Traditional healers and TBAs should be incorporated into Community-based Health Care programmes...the terminology 'traditional healers' suggests that they are traditional health workers and that there is a specific role for this group in Primary Health Care'(Bennett and Maneno,1986:106).

However, the absence of legal recognition remains a serious shortcoming hindering any ready cooperation as well as professional development, as the history of the Tharaka programme has shown. Probably it would be better to distinguish between the strictly legal aspects and planning within any policy option. The Kenyan case demonstrates that informal recognition does not exclude (at least in principle) planning health care services oriented towards co-operation. However, the full cooperation

option certainly requires some sort of legalization of the indigenous system. Among the possible 'positive' choices, then, we could distinguish three different levels of legislation (tab.10.1); these could, in turn, be combined with three different options of 'cooperative planning' within a national health system: incorporation, integration and articulation. Let us examine each possible combination of the two aspects separately.

Among the three planning options, the incorporation choice is certainly less attractive for indigenous practitioners: unless they are not professionals, as in the case of TBAs, how can they appreciate their inclusion 'as the bottom rung in a government medical service, poorly paid and defined by the system as least professional' (MacCormack,1981:426) ? Moreover, this option would be the most 'heavy' in legislative term: recruitment and employment of traditional practitioners would in fact imply not simply their formal recognition, but also a series of regulations regarding their professional work (salaries, duties, hierarchy, etc.)and the way their work was integrated within the cooperative national system. Finally, this option least respects the specific jurisdiction of traditional healing, since it implies a profound re-definition of healing in modern biomedical terms: and I totally agree with the deleterious consequences indicated by Staugard with regard to this type of 'professionalization'.

The second choice, integration, could have some charm for younger, educated and probably urban practitioners of both types wishing to experiment with new forms of syncretic medicine

drawing on the strengths of each type: however, to what extent can the idiosyncratic case of a few skilled individual innovators be generalized? In legislative terms, this planning option would imply a middle choice, including non only formal recognition but also some regulation of professional work, especially when carried out in public clinics. With regard to professional jurisdiction, in this instance its total redefinition would be the endogenous result of cultural innovators, and not the result of exogenous forces as in the previous case.

Finally, the third planning option, which I like to term 'articulation', is , in my opinion, the most advisable, at least in cases such as the Tharaka one. It would not reinforce

Tab.10.1 Legal and Planning Aspects of Policy Options Regarding Cooperation

TYPES OF LEGISLATION	TYPES OF PLANNING		
	Incorporation	Integration	Articulation
formal recognition of Ths and their associations	X	X	X
regulating professional work	X	X	
regulating cooperation activities	X		

biomedical dominance, as does the first option. It would maintain indigenous medicine as an autonomous, independent system with its distinctive features, and would respect its traditional jurisdiction. It would simply require formal recognition either of individual practitioners and of their associations, solving most of the existing problems by leaving them to the management of professional associations (8). It would consider cooperation mainly as a matter of mutual referral between the two different systems, according to the model (outlined above) based on three different types of jurisdictions: exclusive, complementary and supplementary (see 9.3).

The apparent agreement in the existing literature about the value of this approach and the simplicity of its implementation (with respect to the other two planning options) does not explain why it has so seldom been put into practice. A series of factors - structural, cultural and interprofessional - have seriously hindered its implementation (9). Among these, I wish to end this discussion by considering one that is usually overlooked by scholars: the trend towards herbalism.

In their conclusion, 'African medical professions today', in the interesting seminar volume on the topic, Last and Chavunduka (1986:259-69) pointed out the main reasons for the current trend towards herbalism in Africa. Among the 'pull' factors, they list the changing clientele of traditional medicine, whose increasing education has favoured 'a cultural shift of idioms towards a more mechanical ''rationality'' '(ibid.:264); while among the 'push' factors, the powerful thrust

represented by the 'pharmacological lobby' is mentioned. Moreover, in a country such as Kenya, where the Witchcraft Ordinance of 1925 is still in force, herbalism often appears the only obvious way to escape the legal constraints that make healers potentially liable for prosecution. However, I wish to stress the point that the effect of all these powerful forces at a legal, cultural and commercial level can be considered one of the main factors currently preventing the 'articulation' option being implemented, in either its legal or its planning aspects, at least in the Kenyan case. In fact, since the association of herbalists is little more than an appendix of the 'pharmacological lobby', it does not need any particular formal recognition, enjoying as it does the 'patronage' of the latter. Besides, given that traditional healing is coming to be identified with herbalism, its work and language will increasingly be that of a commercial and entrepreneurial activity. Finally, this rules out any consideration of a possible 'articulated cooperation', since the two types of practitioners work at two different levels (business/health care system).

To conclude, I am convinced that the possibility of my hypothesis coming true greatly depends on how the new legal (license, groups recognition) and rational (trend towards herbalism, commercialization) aspects of modern legitimacy will enter into a dialectic relationship with the traditional legitimacy of the community: the Tharaka agao have shown their ability to retain the best of their cultural heritage - healing's holistic approach - without losing the chance of really developing their profession. There still remains the problem of

the absence of a national policy which could ensure the structural conditions - in terms of legal and planning options - within which such a process can fully take place. However, the history of the Tharaka programme shows that the Tharaka agao are already on the way, in their search for their own formula which will blend modern rationality with 'the wisdom of ancestral time'.

FOOTNOTES TO CHAPTER 10

1) Charismatic legitimacy, the third type considered by MacCormack following Weber, is not considered here, being more typical of urban situations in Africa (church-healing, spirit mediumship,etc.).

2) The idea of distinguishing the two types of legitimacy - one from below, arising from grass-roots traditions, and the other one descending from the kind of political legality traditional medicine has acquired in a national health care system - is expressed in Last,1990:349-366.

3) Obviously, there is no literature on the topic as expressed here, since the use of the term 'jurisdiction' is mine: for this reason, I shall review the literature on 'cooperation/ collaboration/utilization'in traditional medicine: most of the scholars take a world-wide perspective, and are not limited only to the African context.

4) Kikhela et al. (1981:96-99) suggest four different possibilities: a) making traditional medicine illegal: this is the policy followed by the majority of colonial administrations in Africa and still retained after independence by countries such as Kenya and Ivory Coast; b) informal recognition of traditional medicine: this is a laissez-faire policy, which implies that formal recognition is exclusively given to biomedicine, whereas the indigenous sector is more or less ignored. The serious negative implication of this policy is that 'it could become an incitement for traditional healers to adopt, successively, the conceptions and practices of bio-mechanically oriented modern medicine' (Staugard,'Traditional Health Care in Botswana' in Last and Chavunduka, 1986:66); c) simple legislation regulating traditional medicine: this option (adopted in many African countries) is limited simply to licensing indigenous practitioners for purely fiscal purposes and controlling certain negative aspects of their practices; d) gradual cooperation with traditional practitioners, oriented towards modification of the whole health care structure. This policy could be implemented in at least three different sub-options: d.1) integration of the two systems, with employment of traditional practitioners by the government; d.2) professionalization of traditional healers, with government control of their activities by means of laws and regulations; and d.3) co-operation between two independent sectors, none of them controlling or regulating the other one. Staugard (ibid.:67-70) considers both the first two as bad choices,since integration would be 'deleterious for the unique character of traditional medicine', acting as a 'kiss of death'; while professionalisation would disrupt the healer's socio-cultural integration in the community,would impose 'bio-mechanical concepts of modern medicine on the traditional healer', 'directing him towards those elements of

traditional healing - like, for example, herbalism - which may be accomodated within the framework of modern medical thinking', and, finally, it would impose 'the curatively biased way of thinking and working of the modern health care sector on the traditional one'. Substantially,this option would miss the notion of an autonomous profession within a framework established by government. The third choice is advocated by Staugard as 'characterised by mutual respect, open-mindedness and interest in learning and modifying conceptions and practices, when necessary'. However, he does not consider the fact that no sector can be 'totally independent': it must be subject to state law.

5) Her typology includes: a)illegalization or evere restriction of traditional practitioners; b) official ignorance of traditional healers; c) nonformal recognition and occasional cooperation with healers; d) formal recognition; e)recruitment and training of practitioners for incorporation or utilization in a modern-sector primary health care (actually two distinct policy options, recruitment or upgrading); f) licensing or registration of traditional practititioners (eventually combined with (d) or (e) above; g) actual integration of the two sectors with mutual referral and cooperation.

6) He distinguishes (1983) four broad categories of policy or systems: a) exclusive, monopolistic systems: only the practice of biomedicine is lawful while all the other forms of healing are illegal; b) tolerant systems: only biomedicine is recognized but, at least to some extent, the practice of other forms of medicine is tolerated (Uganda, Mali, Burkina Faso); c) inclusive systems: systems other than biomedicine are recognized as legal, and their practice coexists independently of it, so long as it conformes to certain standards (Ayurveda, Unani); d) integrated systems: practitioners of traditional medicine are not only recognized and legalized and their work regulated by law, but they are employed in a single recognized institution with integrated training (China, Nepal).

7) His typology includes: a) incorporation, when traditional healers are fully integrated into health care systems as 'first-line' health practitioners: 'in this model the traditional healer functions in a very similar role to that of a Village Health Worker' (ibid.:1184); b) co-operation/ collaboration, when both practitioners of the two systems remain autonomous, retaining their conceptions and methods,but collaborate in forms such as the mutual referral of patients, thus widening the range of the 'formal sector'; c) total integration, when a new healing system is formed through the blending of the two systems (such as in some TBAs programmes).

8) In an interesting article on the case of Zairian Healers' Association, Bibeau (1982:1843-9) wonders what legal status can be given to cultural categories such as witchcraft, spirits and magic; to ritual therapeutics and diagnostic

procedures such as divination. He insists on the fact that both dimensions in traditional medicine, natural and meta-natural, must be assumed within the official legal framework. However, Western-oriented codes of law, such as they generally exist in African states, are incapable of integrating these African concepts and practices.
Stepan states that 'legislative controls of witchcraft are necessary, although it goes without saying that legal intervention in this emotion-loaded field is extremely difficult' (1983:311-2). Then he suggests that a somewhat similar distinction between harmless and possibly harmful practices such as that present in the more 'limited' pattern of colonial criminal laws against witchcraft (those which made it an offence not per se but only when used for harmful purpose) be adopted by legislators 'in considering what methods of healing by supernatural forces can or cannot be used within an intended framework of cooperation with practitioners of traditional medicine' (ibid.:312).

9) The literature on these factors is wide. Among the structural factors, it is worth quoting the lack of implementation of national policy (where there is one), paucity of funds for sponsoring wide-range integration programmes, poor performance of primary health care programmes; among the cultural factors, we can remind the paucity of evaluative findings regarding the effectiveness of traditional practitioners and the lack of understanding of the real differences in the conception and treatment of sickness; finally, among the interprofessional factors we can single out the gap between modern and traditional health practitioners in terms of social status, education and ways of working (Cfr. Pillsbury,1982; Warren et alii, 1982; Green, 1988).

CONCLUSION

THE PROFESSIONAL DEVELOPMENT OF AFRICAN INDIGENOUS MEDICINE

Finally, I must try and answer some of the questions I left unanswered (Cfr. Introduction), via a brief summary of my findings. My starting point is my substantial agreement with Una MacLean's discouraging survey (MacLean,1986) of developments since WHO 'discovered' traditional medicine in 1978 and suggested that African (and other Third World countries') governments might make us of 'traditional practitioners' in Primary Health Care programmes. Little has been done; and that little is often of a questionable nature. We have already identified the 'chemical' and the 'public health' approaches as two different versions of this dubious implementation of WHO policy. The former risks being 'a subtle way of robbing traditional practitioners of their knowledge' (MacLean,1986:30) if the results of any investigation could thereafter be utilized only by established national and international pharmaceutical industries; the latter, by transforming traditional practitioners into primary health workers, risks overlooking the genuine nature of their work, giving rise to poor and contradictory results. The lack of enthusiasm among medical professionals for any involvement with traditional practioners and for the programme's real implementation by national governments (beyond paying lip service) makes the picture, fifteen years after the Alma Ata declaration, certainly not very encouraging.

However, if traditional medicine is not simply 'an

institutional alibi, designed to mask the inadequacies of existing policies, in the hope that health problems will be solved by introducing some more or less imaginary dimension' (1) but instead a reality to be taken seriously into account in the struggle for 'health for all', I believe that a correct approach to such a reality is a necessary starting point. And by 'correct approach' here I mean one that, quite apart from any materia medica involved, takes account of the spiritual, psychotherapeutic and social dimensions of African indigenous medicine. The Tharaka Rural Health Care Programme (THARCAP) has tried to be a step, however partial, in this direction. It suggests that, at a time when the macro-social level is not promising - that is, the level of international and national policies and contexts - it is up to the micro-social level - small-scale pilot projects - to keep hope alive. And, undoubtedly, it is at this local, ethnic level that traditional anthropological methods are better equipped to intervene. It is not just a matter of creating a sort of 'ecological niche' and waiting for better time, but of wondering whether anthropology can really make 'an immediate difference in improving a development policy or program' (Brokensha and Little,1988:9). I hope this work can show that it does: especially when its tools are used within the framework of a more general research action methodology. Participatory action research (PAR) allows the anthropologist to broaden his traditional role by acting as broker, cultural interpreter, and go-between with local people and practitioners on one side and the various agencies and

institutions (government, NGOs, etc.) which affect their lives on the other side (Brokensha and Little,cit:11). This mediating role gives the anthropologist a unique opportunity to turn his knowledge into an asset immediate applicable to development programmes for the benefit of the local community. More than that, my Tharaka experience has taught me that this process is not one-way only: beyond the immediate translation of anthropological knowledge into action, there is the related production of <u>real</u> anthropological knowledge <u>by</u> action. The third part of this work is a testimony of what I mean: it would have never been written if my role has been of a simply external observer. This does not mean that the researcher should confuse himself with the social actors involved in a given situation: his peculiarity lies exactly in maintaining his borderline role mediating between two different cultures.

In this way, the dual goal of developing new knowledge and solving practical problems can be pursued simultaneously: a review of the relevant literature (Prices and Politser, 1980:7) suggests at least five types of knowledge generated through action research. Firstly, it can produce broad categories, to illuminate unrecognized aspects of social reality. I hope that the concept of 'jurisdiction' as used in this work can be considered as such: when I discovered it, I realized it could open a new perspective on many old problems. As I have tried to show in Part I of the work, this concept is the result of the converging analysis of three different aspects: the social division of labour in a segmentary society such as Tharaka (Ch.1), the history of the medical domain within the whole culture (Ch.2),

and the health-seeking behaviour of Tharaka people (Ch.3). It was particularly by analyzing this last aspect that I perceived the existence of a 'cognitive structure of illness' - actually, more a series of cognitive steps ordered to define, classify and act upon health problems than a real structure - which oriented people's behaviour and thought. Although its influence was not certainly exclusive in determining people's coming and going in their search for health (other non-cognitive factors are in fact included in the model I used to analyze health-seeking behaviour, cf. 3.3) and a certain degree of intracultural variation must be taken into account, this cognitive structure certainly played a key role in Tharaka culture. Moreover, when I realized that there was a part of this structure whose contents were obscure to lay people (illness labels, classification and etiology), I turned my attention to those specialists (mugao and muringia) who instead had full knowledge of their meaning. This made me aware of the importance of such esoteric knowledge: by keeping it, these specialists were able to control people's health-seeking behaviour. This is the core of the device I named jurisdiction. Through the process of apprenticeship, I submitted myself to a journey into the reserved territory of the Ugao esoteric knowledge described in Part II. Thereby I was able to identify and analyze the three main cognitive segments of this device: kuringia, the divinatory bewilderment; kurogora, the therapeutic path; and kworia, the healing power. Controlling the meaning of these three segments means to control people's behaviour, since they are the key to the cognitive structure which orientates it.

And their overall connecting pattern - the jurisdiction - is what defines a profession as such. It is this recognized authority over a certain domain - which means a capacity to fully define and manipulate it in people's minds - that constitutes the exclusive character of the occupational group we term 'professional'. To what extent is this etic category broad enough to be applied to other ethnographic contexts? This is a question I cannot answer, since I am only concerned here with my case study: however, I wish to raise it, since I consider it as being crucial for the development of a comparative perspective on (medical) professions.

The second kind of knowledge generated through action research is descriptive information related to various aspects of the reality under consideration. Data of this kind includes notes 'on particular events, processes, things' (Ellen,1984:303): Part III of the work is mainly based on this type of knowledge. It describes a series of events and processes, being stimulated by the THARCAP Project, regarding the development of the agao groups, their interaction with the medical personnel, and the wider social and political relationships implied by the legitimacy of this process. Although the data are not as complete and systematic as the canonic ethnographic method requires, I believe that their interest lies just in the kind of events they allow us to depict. A meeting's minute or a comparative clinical chart describing a patient's case treated jointly by both biomedical and indigenous practitioners, for example, are particular techniques I used to document processes otherwise difficult to be recorded in their making. Where

possible, my direct participant observation supplied further information to integrate and complete them. By including this type of information in my work, the intention is to show the plurality of social processes and relationships involved in any discourse on the development of indigenous medicine. It is my opinion that the concept of jurisdiction can shed further light on this discourse by opening up certain 'dark areas' previously scarcely considered: for example, regarding what I call the professional 'statute' of the mugao profession (cf.8.4), or the model of jurisdiction-based cooperation I describe (cf.Ch.9). The underlying idea is that a jurisdiction is not simply a cognitive device but it involves a series of other dimensions - of a social, economic and political nature: it is, probably, an instance of what Marcel Mauss defined 'total social facts' (Mauss,1950), that is, those overall phenomena implying juridical, economic, religious, political, etc. aspects all at the same time, and revealing the whole of a society and its institutions.

A third type of knowledge generated by action research is the identification of factors in the development and delivery of services: I think we can divide such factors with regard to the development of indigenous medicine into two main categories, cognitive and structural ones. The former includes mainly the particular nature of traditional indigenous medical knowledge, the reciprocal attitudes of the social actors involved in the development process and the issue of therapeutic effectiveness. I hope I have shown with sufficient evidence that Tharaka thought -

as it is expressed in the Ugao - grasps reality in a different way from the postulates of Western logical empiricism, including an 'hidden dimension' that the reduction of theoretical knowledge to purely empirical knowledge rejects. However, this view has been challenged even by most contemporary philosophers of science, who admits that 'if observability is merely a matter of degree, then there seem to be no plausible way of drawing a sharp line on this basis between objects which do and objects which do not exist' (2). The particular nature of this indigenous medical knowledge represents at the same time its richness, difference and value: it is thus something which should be included as an integral part of any development programme. I do agree, in this respect, with those who suggest that we should see 'indigenous knowledge as complementary to conventional science which has proved to be inadequate, on its own, to solve problems of rural development' (Brokensha, Warren and Werner, 1980:8). Even the attitudes of the social actors involved are a paramount factor, particularly those of medical personnel: their common assumption regarding the unscientific nature of traditional medicine and the consequent low status they attribute to it must be carefully tackled if a new attitude has to be created. The Tharaka experience shows the fundamental role that the reciprocal encounter can play in this respect, in order to clarify old - and new - misunderstandings. Finally, the issue of therapeutic effectiveness is also closely connected with these two cognitive factors: what criterion should be used for judging efficacy is a crucial question, which I have tried to answer by showing the importance of the indigenous point of view (in terms

of power) and by distinguishing different types of efficacy (cf.Ch.7).

There are many structural factors affecting the development of indigenous medicine which emerge from the Tharaka project: the role of pharmacological institutes and pharmaceutical industries is certainly one of the most critical. I do not not intend to deny the value of biochemical and pharmacological analyses into the active principles of herbal medicines: this was required as part of the project itself. To strengthen a nation's own pharmacopoeia is a legitimate aim if it does not imply an implicit expropriation of healers'secret knowledge. A second structural factor of critical importance is represented by political power. Indigenous medicine is power, as we have seen: it implies a certain power. But, to what extent this clinical power can be translated into a political, organized power in the form of a pressure group? And, suppose it can (as has happened, at least partially, in the Tharaka case), in what way will it gain the support of the other powers in the political arena? The roles played by government policy, the modern medical profession and the local community are, in this respect, fundamental in order to gain a certain degree of both modern (top-down) and traditional (bottom-up) legitimacy to the development of indigenous medicine. A further critical factor is represented by juridical and deontological issues: how can legal obstacles be removed in order to achieve the full recognition and registration of individual practioners and their groups? It is not a rhetorical question in countries like Kenya where the Witchcraft

Ordinance is still in force: and the long-troubled history of licensing individuals and registering groups in Tharaka is particularly significant in this respect. How can quacks be controlled? And, if this requires some form of institutionalization of knowledge through a training programme, how can the proper teachers, syllabus, teaching and assessment methods be sorted out? And, to what extent are the practitioners really willing to follow them? Finally, the last structural factor regards economic resources: the critical condition of many African national economies overwhelmed by foreign debt makes the total resources available for health care out in the national budget pretty small. What money is available becomes the subject of fierce competition, easily won by existing biomedical personnel and institutions for their maintainance: in this situation, who should pay for the development of indigenous medicine? The need for outside economic aid becomes evident, but the question remains: for doing what? Small-scale pilot projects or national schemes? So far, the former seem to represent the most promising solution, waiting for a more stable political commitment at the national level. If so, the role that both local and foreign non-governmental organizations (NGOs) can play in the management of such small projects becomes crucial.

The fourth type of knowledge created by action research is prescriptive guidelines for practitioners: these are the more practical and organizational aspects of PAR. In the Tharaka case this has meant suggesting a model of 'comprehensive community-based health care' as illustrated in Chapter 9. Using a role-analysis approach, I was able to gradually build up the model

together with the local communities, by identifying the specific role of each practitioner and the proper kind of relationships among themselves. Further, this model is based on a certain pattern of structured coexistence of modern and traditional medical systems within the same health care configuration: it is the approach of 'structured cooperation', where the training of practitioners ensures that each is able and willing to recognize the possibilities and limitations of his own and other systems and to act accordingly (3), thus avoiding any loss of valuable time that might otherwise endanger the patient.

The last kind of knowledge generated through action research is the development of applied research methods: in the Tharaka case, this is the result of the particularly participatory method applied there (PAR). This innovative approach was designed to mobilize local resources to solve development problems in a self-sustaining way: the assumption was that an oriented social change was possible through planned, controlled forms of cultural contacts. These forms were represented by three kind of stimuli introduced by the project: the support given to the creation of healers' groups, a community focus in primary health care activities, and a cooperation model based on the articulation of biomedical and indigenous practitioners according to their respective jurisdictions in people's minds. What I called the 'intervention level' - the degree of external input by foreign actors into a given social situation - was strictly limited to these three stimuli. The result was the mobilization of the indigenous actors involved in the social situation

considered - particularly, the practitioners and their communities - towards new forms of self-development. This kind of oriented social change was thus the result of what I called the 'action level' - the mobilization of the internal forces of the local community - and of its interaction with the intervention level.

I believe this applied participatory approach has proved its effectiveness in the Tharaka case according to the results obtained; its repeatableness elsewhere becomes a problem of comparison. However, if some cautious conclusions of general value can be drawn from one ethnographic case, I think they have meaning for any development process in African indigenous medicine. In my opinion, the results of the Tharaka project question any mechanical application of a professionalization process intended as a replica of the Western model of development for the medical professions. The peculiar historical features of such process make it unrepeatable elsewhere (4). Therefore, in my opinion there is no chance that a professionalization process, implemented as a development-from-above and institutionalizing an otherwise autonomous corpus of knowledge and activities, can be applied to African medicine. This approach can possibily work where a 'great tradition' of indigenous medicine already exists in an institutionalized form, as it does in Asia. I do not think it can work where medicine is <u>not</u> traditionally a functionally and structurally differentiated social institution, as it is not in the African context. Medical knowledge and practice is part of culture, it is created within a cultural context and makes sense in that context. The forms in which it has been historically

expressed are a product of the socio-cultural and physical environment and the technological level of the society. Instead of imposing on all this an alien idea of professionalization, would it not be better to look at the real contents of indigenous knowledge and practice, and do so together with the directly interested subjects themselves? The Tharaka project shows that, in this way, it is possible to discover that the word 'profession' can have different meanings in various cultural contexts; and that the direction of what we call 'development' is not necessarily along the well-known path mapped out by Westerners.

FOOTNOTES TO CONCLUSION

1) Bernard Hours, 'African Medicine as an Alibi and as a Reality' in Maclean,1986:46: the same author sorts out several reasons for traditional medicine being used as an alibi by official institutions. It is worth to note what Kenneth King pointed out in the same symposium on 'African Medicine in the Modern World' held in Edinburgh on 10-11 December, 1986: 'just at the period when WHO was discovering African medicine the ILO was discovering the virtues of the 'informal sector' in Africa. UNESCO meanwhile was discovering the attractions of informal African education... as a medium of instruction' (reported in Maclean,cit.:1).

2) It a quotation from Mulkay (1979:31), cited from Grandy (1973:71). See also Berger and Luckman (1966) and, more specifically, the classic essay of Robin Horton on similarities and differences between Western scientific thought and African traditional thought (1967); Janzen has also argued that rationality is not synonymous with modern experimental science (1978).

3) The definition of 'structured cooperation' is taken from Unschuld (1976:9). The same author sorts out two other forms of possible 'structured coexistence': 'structured competition', when two or more medical systems, legally regulated and supervised, compete in society for the same secondary resources (meaning material and non-material rewards that accrue to the practitioners of medicine through their practice) in society; and 'integration', defined as the situation where relevant primary resources (meaning drugs, healing techniques, equipments and facilities) are equally accessible to the previously different manpower groups with specialization occuring on the same basis as it occurs in Western medicine (ibid.).

4) The rise of the medical profession in Europe and North America and the way biomedicine, since the eighteenth century,laid the basis for its domination over all alternative healing systems, is the subject of a vast literature: among the others, I can quote the work of Larson (1977) for her stress on the importance of the market and of achieving a monopoly of it as an important step in the professionalization of biomedicine. Of particular interest is the parallel drawn by Steven Feierman (1979) between the plurality of healing systems still existing in Tudor and Stuart England and the situation of 'medical pluralism' existing in many parts of the twentieth century Thirld World.

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APPENDICES

APPENDIX A

List of the Research Material

1. PRELIMINARY SURVEY

a) Interviews

1. Rinaldo Bonadio	CUAMM doctor	4-7-1984
2. Silas Njeru	Catholic Bishop of Meru	13-8-1984
3. Flavio Consonni	CUAMM doctor	16-8-1984
4. Sr.Luigia	nurse	17-8-1984
5. Sr.Francesca	public health nurse	20-8-1984
6. Bartolomeo Draghi	CUAMM doctor	23-8-1984
7. M'Mugwongo	mugao	28-8-1984
8. Njoeli Muchiri	mugao	4-9-1984
9. M'Muthoro	mugao	18-9-1984
10.M'Kariiguua	mugao	20-9-1984
11.M'Meeni	mugao	25-9-1984
12.Giorgi Pellis	CUAMM doctor	4-10-1984

b) Questionnaires

34 Questionnaires were administered to Village Health Workers

2. THE PROJECT

a) Interviews with Tharaka Health Practitioners

1. Muthoro Kiburi	mugao	Kiandere (age-group)	Kanjiiru (clan)	23-8-1985
2. Njoeli Muchiri	mugao	Mwarakanywa	Gankuyu	5-9-1985
3. Kijiru Nkaratu	mugao	Kiarutha	Kanjiiru	6-9-1985

4.	Kariigua Mbura	mugao	Kiambamba	Gantue	11-9-1985
5.	Kigwato M'Mukindia	mugao	Kianjuri	Kanthakame	23-9-1985
6.	Mugambi Mwarania	mugao	Kaburia	Nyaga	25-9-1985
7.	Makembo Rimbeira	mugao	Kiandere	Kitherini	26-9-1985
8.	Kiaya Kanyoro	mugao	Kaburia	Ndegi	27-9-1985
9.	Mutegi Kathumbi	mugao	Kianjuri	Mwagitiri	4-10-1985
10.	Mageu Iguna	mugao	Nkonge	Kirundu	15-10-1985
11.	Ntugu Njeru	mugao	Kiruja	Nyaga	16-10-1985
12.	Muchiri Kirimu	mugao	Kaburia	Kamarao	16-10-1985
13.	Kabete Kamwara	muago	Kiandere	Kamugemia	17-10-1985
14.	Nyamu Kathumbi	mugao		Mwagitiri	29-10-1985
15.	Gichugu Nkoru	mugao	Kiarutha	Ncuria	29-10-1985
16.	Kinyua Nkoru	mugao	Mwarakania	Ncuria	29-10-1985
17.	Mwarania Tankingo	mugao	Kiruja	Kanjiiru	30-10-1985
18.	Karigu Mutiga	mugao	Kianjuri	Nyaga	30-10-1985
19.	Mwaria Rwito	mugao	Kaburia	Ukujiu	5-11-1985
20.	Rugera Rwito	mugao	Kaburia	Ukujiu	6-11-1985
21.	Karauki Muthare	mugao	Kianjuri	Nyaga	7-11-1985
22.	Mbobori Kwarema	mugao	Kiruja	Mbogoni	7-11-1985
23.	Mang'oro Kariiguua	mugao	Kianjuri	Nyaga	11-11-1985
24.	Kunyia Runguma	mugao	Kiarutha	Mwagitiri	12-11-1985
25.	M'Thiora Karima	mugao	Kaburia	Kanjogu	13-11-1985
26.	Mukumu Kabua	mugao	Kiruja	Mbogoni	15-11-1985
27.	M'Muriki Mirigaru	mugao	Mbae	Nyaga	16-11-1985
28.	Ngochi Muthurwa	mugao	Kianjuri	Ndegi	18-11-1985
29.	Rukungi Mungania	mugao	Kiarutha	Nyaga	19-11-1985
30.	M'Gaicima Makoro	mugao	Nkonge	Muruguru	20-11-1985

31.Metambu Karangu	mugao	Kiarweni	Kamurige	21-11-1985
32.M'Kaibi Kaimba	mugao	Kaburia	Kagunda	22-11-1985
33.Nkoru Mwenda	mugao	Ciamunaika	Gankina	23-11-1985
34.Mburuki Muthia	mugao	Kiangigi	Ukojiu	25-11-1985
35.Regina Nkima	mugao	Kaburia	Nyaga	25-11-1985
36.M'Thiora Mpempe	mugao			26-11-1985
37.Muchee Mwiru	mugao	Kiambururi	Muruguru	28-11-1985
38.Getuma Mwaria	mugao	Kiathamba	Igoro	28-11-1985
39.Javet Iguna	mugao			29-11-1985
40.Maingi Meni	mugao	Kaburia	Kamurige	29-11-1985
41.Mary Kondu	mugao	Kaburia	Nyaga	30-11-1985
42.Mbiru Mbondu	mugao	Kiandere	Muruguru	2-12-1985
43.Mucunku Kathing'ora	mugao	Kiarutha	Gankina	2-12-1985
44.Ngunku Kuyoga	mugao	Kiandere	Ntugi	3-12-1985
45.Angelina Kambura	mugao	Kiarutha	Kamarao	5-12-1985
46.Kabuka Thambura	muringia	Kiandere	Gankuyu	30-9-1985
47.Gauki Mututua	muringia	Kiandere	Kamugemia	17-10-1985
48.Mukwaiti Konmbaru	muringia	Kiruja	Kamurige	14-11-1985
49.Kajira Makembo	muringia	Nkonge	Gankina	20-11-1985
50.Ester Chuka	kiroria	Kianjuri	Chuka	4-12-1985
51.Kanyoro Murige	mutani	Kaburia	Gankina	19-11-1985
52.M'Kimbo Mungania	wa aka mutani	Kianjuri	Gankuyu	25-11-1985
53.Kathare Karema	mutani	Kaburia	Kanjogu	4-12-1985

b) n.50 Interviews with TBAs (not reported here)

c) Patients' Case Histories

1. Kabogo	Ndegi (clan)	17-4-1986
2. Ciampui	Kamugao	21-4-1986
3. Kaburi	Utonga	21-4-1986
4. Kanyoro	Njiru	12-5-1986
5. Kambura	Nyaga	16-5-1986
6. Kiguara	Nyaga	19-5-1986
7. Kaindi	Kamurige	19-5-1986
8. Muthamia		19-5-1986
9. Nyamu	Kamugao	26-5-1986
10.Mati		4-6-1986
11.Gatembi	Nyaga	5-6-1986
12.Tabitha	Nyaga	5-6-1986
13.Kimbu	Ncuria	14-8-1986
14.Ruguru	Kamurige	15-8-1986
15.Muthoni	Muruguru	16-8-1986
16.Kamene	Gankina	13-5-1986
17.Kiaira	Kamurige	14-5-1986
18.Mukauru	Muruguru	14-5-1986
19.Nkima	Kamurige	20-5-1986
20.Nkathe	Kamurige	21-5-1986
21.Kagondu	Igoro	22-5-1986
22.Gakunyi	Igoro	23-5-1986
23.Cianjoka	Kamurige	17-6-1986
24.Karea	Muruguru	19-6-1986
25.Jevina	Muruguru	17-7-1986
26.Gaichu	Kamurige	18-7-1986

27.Karigi	Kamurige	17-7-1986
28.Ntue	Kagunda	17-7-1986
29.Karemi	Gankina	25-7-1986
30.Kaura	Kathoga	18-8-1986

d) Interviews with the "Agao" on their Therapeutic Treatments

1. Kinyua Nkoru	nthata (infertility)	12-12-1986
2. Rukungi Mungania	nthata	14-12-1986
3. Nkoru Mwenda	nthata	9-1-1987
4. Kigwato M'Mukindia	nthata	16-1-1987
5. M'Mburuki Muthia	gichonono (gonorrhoea)	24-6-1986
6. Javet Iguna	gichonono	7-7-1986
7. Kigwato M'Mukindia	gichonono	10-8-1986
8. Muthoro Kiburi	gichonono	17-10-1986
9. Kabete Kamwara	nyongo (malaria)	12-6-1986
10.Rukungi Mungania	nyongo	15-9-1986
11.Kigwato M'Mukindia	nyongo	22-9-1986
12.Muthoro Kiburi	nyongo	20-10-1986
13.Kabete Kamwara	rwaro and njoka chia nda (diarrhoea and worms)	2-7-1986
14.Kinyua Nkoru	rwaro and njoka chia nda	5-8-1986
15.Mukumbu Kabua	rwaro and njoka chia nda	11-9-1986
16.Mang'oro Kariiguua	rwaro and njoka chia nda	25-9-1986

e) Minutes of the Meetings of the "Agao" Groups (1987-1992)

n. 35 minutes of Kithino Group

n. 11 minutes of Kibuka Group

n. 21 minutes of Muthitwa Group

n. 25 minutes of Kamarandi Group

n. 23 minutes of Kamanyaki Group

3. FOLLOW-UP STUDY

a) Interviews

1. Giancarlo Ometto	CUAM doctor	9-7-1992
2. Kigwato M'Mukindia	mugao	8-8-1992
3. Mukumbu Kabua	mugao	9-8-1992
4. Nkoru Mwenda	mugao	10-8-1992
5. Joseph Gichugu	mugao	12-8-1992
6. Rukungi Mungania	mugao	14-8-1992
7. Araigua Stanley	officer of the Herbalists'Association	17-8-1992
8. Alex Muchee	ex-field assistant	18-8-1992
9. Dr.Wanyama	Medical coordinator *diocese of Meru*	12-8-1992
10.Benson Ngoci	chief of Tunyai Location	*12-8-1992*
11.Rita Drago	CUAMM nurse	13-8-1992
12.F.Orazio Mazzucchi	Catholic priest	13-8-1992
13.Paolina Njai	midwife (Nkubu Hosp.)	16-8-1992
14.Andrew Nyaga Kagembe	Pentecostal pastor	17-8-1992
15.Javet Mutuura	health worker	17-8-1992
16.Angela Kanyua	nurse (Gatunga disp.)	17-8-1992
17.Ibrahim Kabuku	Methodist pastor	18-8-1992
18.Muthengi Mwarania	African Inland pastor	18-8-1992
19.Sr.Leonella Sgorbati	tutor Community Nurses School of Nkubu Hosp.	19-8-1992

APPENDIX B

A Survey on the Utilization of Biomedical Facilities in Tharaka

In 1985, a statistical survey was conducted by Dr. Agolini on the utilization of Nkubu hospital and Matiri and Gatunga dispensaries by Tharaka people, using the facilities' admissions registers. Even though the data collected cannot be considered comprehensive since they did not include other government and missionary dispensaries and hospitals used by Tharaka people in Meru district, they can offer a non-probability sample of Tharaka patients. For the first time we are at least able to identify some interesting variables specifically for Tharaka.

The first findings are about the provenance of attendance in order to identify the real catchment area of the three facilities. Tharakans are a clear minority (about 4.5 % of all out-patients at Nkubu hospital, where an average of 500-600 patients attend daily). The provenance of the Tharakans is almost exclusively from South (Tunyai and Chiakariga) and Central Tharaka (Mariamnti; whereas Northern Tharaka and some farthest sublocations like Kamanyaki and Kanjoro are very little represented. The two dispensaries of Matiri and Gatunga mainly cover the surroundings areas, the former serving Chakariga and Kamanyaki and the latter Nkundi, Gatunga and Marimanti (Tab.B.1).

Of particular interest are the morbidity prevalence data (Tab.B.2): the commonest disease among Tharaka is malaria (49.3%), followed a long way behind by abdominal problems (17.1%) and pulmonary diseases (14.7%). It is significant that all these are endemic or infectious diseases.

If we consider the age of patients (Fig.B.1), it is quite evident that the highest rate of attendance is among the under-five years old (33.8%); overall, the under-twenty's total 58.4%.

Gender differences are also significant: female patients tend to visit the dispensaries more often than male patients (about 3/5 of attendance is female) while in Nkubu hospital gender differences are much more balanced (a slight predominance of males).

To sum up, the gender and age pattern of utilization seems to sketch a prevalence of non-adults (especially infants under-five) and female patients, when the total out-patient attendance at the three facilities is considered.

Of some interest is the way seasonal cycles influence patients'attendance (Tab.B.3). Daily movements of patients in various seasons shows a prevalence of attendance during the nthano (long rainy season of March-June) in Nkubu and Gatunga;

while in Matiri the most crucial season is muratho (the short dry season of December-March). It is worth to note that the lenght of each period is not homogeneous, but varies sensibly.

To conclude, it seems to me that the statistical findings of this utlization survey open up more questions than answers. Why,e.g., do no patient attend at Nkubu Hospital from Kanyoro, which is the closest Tharaka sublocation? Why so few male adults among the patients at all the three facilities? Why in Matiri does the seasonal pattern of patients differ from that at Nkubu and Gatunga? And so on. I am sure this is a kind of question the statistical survey by itself could not have answered: another different methodological approach is needed.

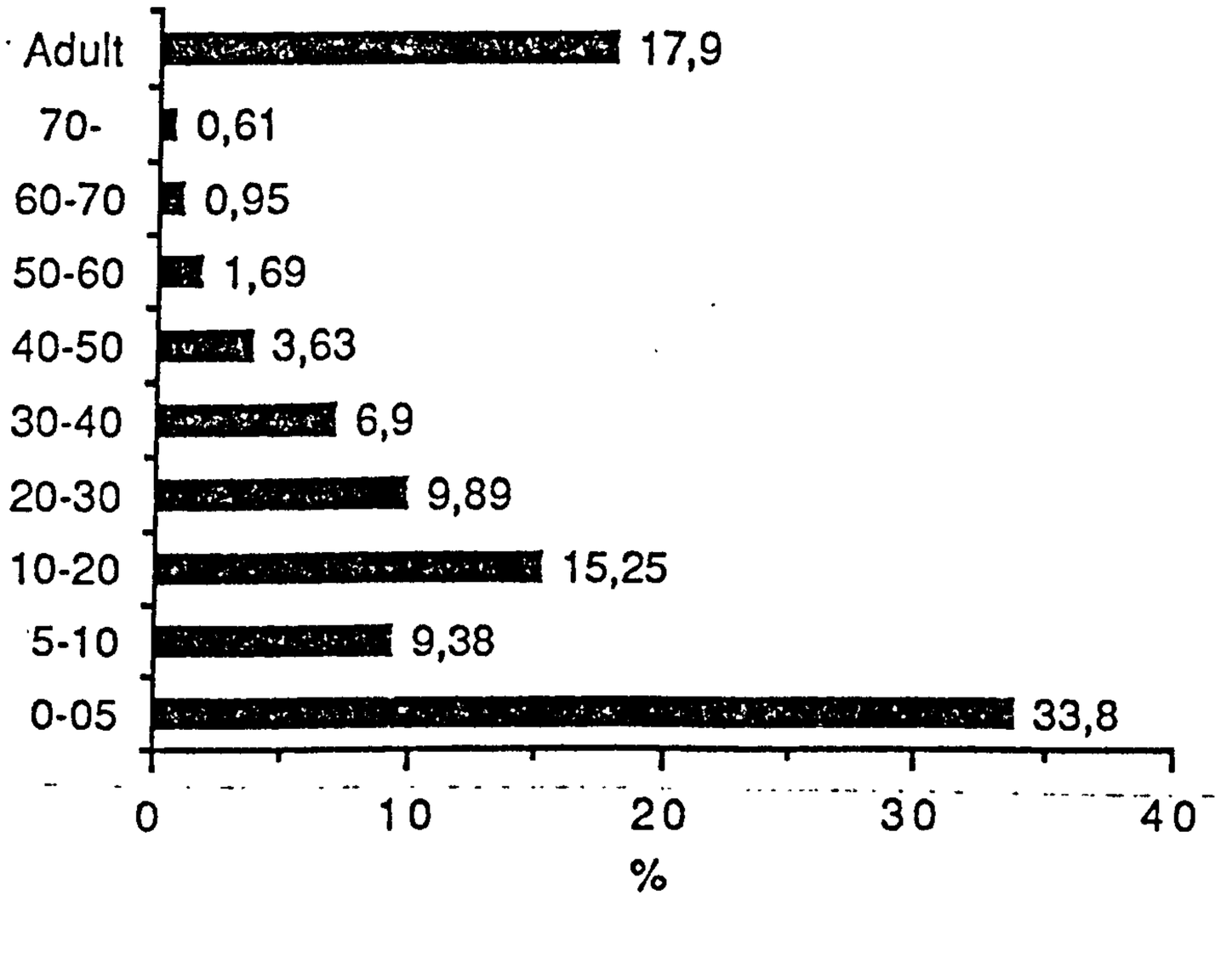
Fig.B.1 Out-patients flows to Gatunga, Matiri and Nkubu facilities according to Tharaka Sub-locations.

		Gatunga	Matiri	Nkubu
Tunyai	%	2.50	10.00	87.50
Chiakariga	%	9.50	53.30	37.10
Kamanyaki	%	2.90	97.10	
Nkundi	%	95.60		4.30
Kanyuro	%	57.10	42.80	
Marimanti	%	84.00	0.40	15.40
Thurima	%	100.00		
Gatunga	%	95.90	0.20	3.80
Kanjoro	%	100.00		
Kathangacini	%	97.50		2.40
Gatue	%	98.30		1.60

Fig.B.2 Most common diseases among Tharaka patients

Malaria	%	49.30
Abdominal pains	%	17.10
Pulmonary diseases	%	14.70
General medicine	%	6.90
Orthopaedics	%	2.60
Diarrhoea	%	2.20
Skin diseases	%	2.10
Head-ache	%	1.40
Anaemia	%	1.20
Others	%	2.50
Total	%	100.00

Fig.B.3 Tharaka patients'age-sets



Note. The range of the first two classes (0-5 and 5-10) is halved for medical interest. the class 'adult' includes all those patients of unspecified age.

Fig.B.4 Patterns of patients'attendance according to the seasons

		SEASONS			
		Kiatho	Muratho	Nthano	Thano
Nkubu	%	11.50	25.20	32.30	30.00
Matiri	%	19.60	32.60	26.40	21.40
Gatunga	%	16.20	29.80	31.60	22.70

Note. Tharaka four season are so named:

- kiatho: short rainy season (from mid-October to December)
- muratho: short dry season (from January to mid-March)
- nthano: long rainy season (from mid-March to mid-June)
- thano: long dry season (from mid-June to mid-October)

APPENDIX C

Thirty Illness Episodes

The following is a summary based on the interviews and my field notes of each of the thirty illness episodes I collected in the two research areas of Kibuka and Kariekajeru (Cfr.Chapter Two). The first fifteen cases are those registered in Kibuka area; the following fifteen are those registered in Kariekajeru.

Case 1: Kabogo

Kabogo is a 34 year old woman of Ndegi clan living in Kibuka; she has no education. She has been married for 12 years without getting a child; her problem started a long time before marriage when she stayed even for long periods without menses. She went to about 15 agao (traditional healers) for this problem since 1974, some of them even outside Tharaka (Kamba healers): after the treatment of one of them, the mugao Gichugu of Kibuka, in 1982 she started experiencing irregular periods. Menstruation was accompanied by strong abdominal pains and backache, which prevented her from eating and walking; when she had them in the bush away from home she had to sleep there. Kabogo also went to many dispensaries and health centres in Tharaka and outside: Chiakariga, Ishiara, Marimanti, Tunyai, Mitunguu and Kathangacini. The nurses there were always unable to diagnose her problem, simply giving her some tablets. She is quite dissatisfied with the treatment she received there, while she trusts more the mugao who partially healed her. Her wish is now to go to a big hospital for examination, but her husband is too poor to afford to pay the fee. Therefore she continues to be treated by agao although she is increasingly hopeless.

Case 2: Ciampui

Ciampui is a 35 year old illiterate woman of Kamugao clan married in Nyaga and living in Muthitwa (Kibuka). After marriage she had two children but both of them died, in 1969 and in 1972. It was just after the second child died in 1972 that her problem started: her menstruation became irregular and prolonged (up to 10-14 days) and the flow was very dilute. Her back was also paining her a lot. Because of these problems she has gone to governmental as well private hospitals: Chogoria (1980), Ishiara (1983), Nkubu (1978 and 1985) and Meru. In Chogoria and Meru she was told that no doctor was present ; in Nkubu she was examined and in Ishiara she was 'washed' without receiving any explanation. Since she was quite dissatisfied aith the hospital treatment, she moved to the agao, visiting ten of them in Tharaka and outside (Chuka healers). After the treatment of the last

mugao (Kinyua of Kibuka) in February '86, she has improved: the menstrual days last the normal length and the flow is thicker. She has also tried a muringia (diviner) who told her that the sickness was caused by mpingo (a type of sorcery). She now hopes to get another child.

Case 3: Kaburi

Kaburi is a 34 year old illiterate woman of Utonga clan living in Muthitwa (Kibuka). She got married in Kamurige clan in 1973 but because of failing to get a child she divorced in February 1986. She had two pregnancies in 1980 and 1984: but both of them resulted in miscarriage after three or four months After each miscarriage she went to a hospital: Nkubu for the first one and Meru for the last one. After that, since 1984 she started seeking help from agao, being treated by three of them even at home together with the husband. She also went to two aringia who told her she had kioo and rurigi (two types of sorcery). But even after this she was not pregnant again and the husband divorced. She is now trying with another mugao, hoping to get success.

Case 4: Kanyoro

Kanyoro is a 14 years old boy of Njeru clan living in Kiriria (Kibuka). The first time I met him he was lying beside the main road surrounded by some people: they told me he had just had a nervous attack and asked me for help. I brought him to Nkubu hospital and later on he told me his story. His father was dead and his problem started in November 1985 after he was beaten by other boys. They were just joking together at his aunt's home when they knocked him down wounding him on the head. The boy was plainly so shocked that he was unable to sleep overnight and the following day started stripping off his clothes and running away from home. After three days he went to Meru and later to Nkubu hospitals. After leaving the hospital, he was feeling better; but after some time he started feeling dizzy and behaving strangely, wearing bells on his legs and going about in rags. His mother decided to take him back to the hospital but, on the way, he refused to go there picking up stones with the intention of beating her. He demanded to be treated by a mugao, and even the people around watching the scene suggested the mother agree to the request. He was taken to mugao Gichugu in Kibuka and treated for four days until he got better and went back to school (he is attending Standard 5). Even now, after hospital treatment, if he feels sick he wants to go to mugao again.

Case 5: Kambura

Kambura, a 23 year old woman of Kanyaga clan who attended Standard III, is living in Kibuka. She was married for a short period (less than a year) until divorced. In January this year she started experiencing periodical pains at the abdomen, dizziness and reduced eye sight; her body had become too weak and very thin. Sometimes she could not even walk. She went to Tunyai dispensary twice with no result. People around thought she had worms and suggested she buy some shop drugs: her mother went to buy them in Tunyai and Mitunguu. After taking the drugs she vomited very seriously, feeling even worse than before. Thereafter her mother went to mugao Kinyua who came to treat her and divine for her at home. The result was urogi (bewitchment) and he performed the appropriate ritual.Later the pain in the stomach stopped and she is now feeling better. She is quite contented with the treatment of the mugao but she would like to go to the hospital because of her eye problem.

Case 6: Kiguara

Kiguara is a very old woman (perhaps 70 years old) of Ntakira clan married in Nyaga and living in Kibuka: she is feeling general body pains, especially in the neck, probably a slight form of malaria. She think that her problem started in 1985 when fetching water she fell into the Numberekini swamp. It is, in fact, after she was seriously injured because of the accident that her problem started. She went to Marebe and Tunyai dispensaries and to a private nurse: she was given medicines but she failed to improve. So she began taking herbs she personally prepared: four different types, she boils and drinks the juice. She says that she was never taught about them: when young, she was told during a dream. When she starts passing yellowish urine that is the sign she is recovering. People sometimes come to her homestead to be given the medicine she prepares: most of them are family members, some are villagers, others come from further afield. She does not charge anything for that, but when people recover they usually come to express their gratitude with some gifts. Kiguara would have liked to continue with her knowledge, becoming a mugao, but her husband opposed that.

Case 7: Kaindi

Kaindi is a 50 year old woman of Kamurige clan married in Kirunduni and living in Kibuka; she attended Standard II. She started falling sick five years ago, periodically suffering from stomach ache and headache. She has gone to many dispensaries (Tunyai, Mitunguu, Chiakariga,Marebe and Kaaru) and Nkubu hospital without any result: she is getting very thin. She has also taken some herbs when she saw old women preparing them: but she did not improve. She refuses to go to any mugao because, she

says, the church she belongs to (Presbyterian Church of East Africa) disapproves of that. She is convinced that a mugao could not heal her. Now she thinks that, since her problem is unknown, the best thing to do is to go to a hospital for examination to discover whether her disease is really incurable or not.

Case 8: Muthamia

Muthamia is not a mutharaka but an Imenti from the Mount Kenya highlands who settled in Kibuka in 1965, when searching for a piece of land. He is now about 60 years old and illiterate. Since the time he came to Tharaka, he started taking herbs to protect himself from malaria, very common there. He was told of the herbs during the World War II when a soldier, a Sudanese comrade-in-arms (Azande), taught him while in Mogadishu. He is now suffering from a cough. He has neither gone to any hospital nor to a mugao: he only trusts his own herbs.

Case 9: Nyamu

Nyamu is a 25 year old married man of Kamugao clan who lives in Gakurungu (Kibuka); he has attended Standard IV. During the last few weeks he has started suffering from strong chest pains and, he says, his heart is beating too fast. Sometimes is also unable to see properly. People around told him it probably was malaria: then he went to Tunyai and Marebe dispensary where he was given tablets which he regularly took with no result. Therefore he decided to a mugao: he went to Kinyua accompanied by his brother and uncle. He was treated, and slept there until the next day, when he went home. Then he fell very sick again and was brought back to the mugao by his mother,sisters and two wives. The mugao divined for him and said he was cursed (kirumi) by his father because he did not follow the instructions he left before dying. I found him at Kinyua's home immediately after the treatment. He was a bit better, but still quite upset. The mugao suggested he went to the hospital: he agreed and was also thinking of being examined because he was afraid of his heart problem. I accompanied him to Nkubu hospital.

Case 10: Mati

Mati is a 45 year old married woman of Mwagitiri clan living in Kibuka who attended Standard III. She started falling sick in October 1976 suffering from stomach ache, dizziness, headache and general weakness. The disease was particularly acute between December '84 and February '85 when she was treated as an inpatient in Chogoria hospital and after that partially recovered. Before, she had gone to Nkubu (1980) and later to Meru hospital (1985) where she had a stools,blood and urine examination. Every

time the husband accompanied her to the hospital. She is particularly satisfied with the treatment received in Chogoria hospital because at that time she was afraid of dying; however the problem still lasts, although less severe. She has never gone to a mugao and is not planning to go because her husband does not like them and, she says, 'agao do not treat internal diseases like hers, but only external illnesses due to urogi'.

Case 11: Gatembi

Gatembi is an elderly woman about 55 years old of Kanjogu clan married in Nyaga and living in Kibuka. She was recently suffering from severe stomach ache: she first went to Gatoto (a private nurse) where she received an injection. Immediately after that she took some herbs the husband (who is a mugao) prepared for her. She recovered from her problem but later started having coughing and headache. She then took some shop drugs but did not improve; therefore the husband wanted her to go to the hospital and gave her some money for that. She has gone some days ago to Nkubu hospital and is still taking the tablets she received.

Case 12: Tabitha

Tabitha is an elder woman about 75 years old of Nyaga clan married in Igoro and living in Kibuka. She is a widow living alone, the sons are working in Mombasa. During the last year she has probably been affected by malaria: she had diarrhoea associated with vomiting, headache and general body pains. She thinks it is nyongo, according to what people say when you are vomiting yellowish and greenish substance. She thinks that the best treatment for that is to buy shop drugs or to go to the dispensary for an injection: but because she is very poor she cannot afford that.Therefore she has boiled some herbs together with millet leaves. She has also gone to mugao Gichugu who refused to treat her because she had no money. After that she has decided to look for help from another mugao who is living very far on Kanjagi Hills: but he is a relative of her mother and he treated her for free. She received some herbs to take and she has improved a bit. But her problem still persists and she is now looking for money to seek help from the dispensary.

Case 13: Kimbu

Kimbu, a 40 year old man of Ncuria clan, is living in Kitheno (Kibuka); he has attended Standard VI. From April 1985 he started suffering from severe backache to the extent that he could not even bend. He first went to Nkubu hospital six times: he had an x-ray and urine and stools examination but he did not recover. When people around told him that it could be gichonono

(venereal disease), he decided to go to a muringia: he went to two of them, Gauki and Kagondo, and both told him that the cause of his problem was kibitana (sexual impurity). Thereafter he was treated at home by mugao M'Machebe together with the woman who was supposed to have defiled him. Now his problem seems to be much less acute than before and he can even work properly in the shamba (garden).

Case 14: Ruguru

Ruguru is an elderly woman of Kanjogu clan married in Kamurige and living in Kitheno (Kibuka). Last year she became seriously sick with acute pains in the head and ribs. She was admitted in Meru hospital for two weeks but she did not recover. When she came back home, people around suggested her she call a mugao called Rwanda, who came and treated her for gendaga (misfortune).After three days, she says, she was completely recovered. She is very much convinced that her problem was caused by gendaga and that only agao can treat it.

Case 15: Muthoni

Muthoni is a 17 year old girl of Muruguru clan living in Kiriria (Kibuka) and attending Form I. Two years ago,in 1984, she started suffering from severe pains in the feet and her legs became swollen. She went to Meru, Nkubu and Chogoria hospitals, she was examined and treated and she improved a bit; but the doctors were unable to diagnose her problem. Her mother then suggested to go to a kiroria (prophet) to ask for prayers.They went together to the kiroria called Chuka who gave her some blessed water for washing her legs. She also told her that the cause of the disease was the bewitchment made by a person who was jealous. The girl is very satisfied with the 'water' she received from the kiroria , because after using it she has almost completely recovered.

Case 16: Kamene

Kamene is a 40 year old illiterate woman of Muruguru clan married in Gankina and living in Kirukuma (Kariekajeru). She started getting sick in December '85 when she miscarried and later began suffering heart problems and severe headaches. Since then the husband has taken her to Nkubu hospital and to Kamanyaki dispensary twice: in Nkubu she was told to come back for examination but when she went,after four days, she was not examined because there was no one to do it (after a journey of 70 Km!). At the same time the husband went to call a mugao who came to treat her at home. She was given a medicine and her heart

problem ceased but the headache persisted. He also went to two different aringia himself and both told him it was urogi (bewitchment). Even the wife went to another muringia who told her the same. Now the husband is looking for money to go and call another mugao suggested by a muringia. At the same time he wants to bring his wife back to Nkubu hospital to be examined.

Case 17: Kiaira

Kiaira is an elder about 65 years old of Kamurige clan living in Kariekajeru. He became blind between October '85 and February '86 after he was hurt by a tree branch he was cutting: the eyes swelled a lot with sharp pains. People around advised him to go to a muringia: he went to a famous old muringia and he was told the cause was gendaga (misfortune). Thereafter, he went to a mugao to be treated. The ritual was performed and he was given a medicine to drink; but he did not recover. So he decided to go to Ishiara hospital but once there he was directed to a better hospital. So he went to Nkubu, where he remained for seven days until the swelling and pain disappeared. He is satisfied with the treatment, although he is unable to see any longer.

Case 18: Mukauru

Mukauru is an illiterate woman about 50 years old of Muruguru clan married in Kamurige and living in Kamuthanga (Kariekajeru). Five years ago she started suffering heart problems with severe pains in the body, especially on the neck: sometimes she is even unable to work or to fetch water from the Tana river carrying the gourd. She has gone to several hospitals and dispensaries in Tharaka and outside: Kathwana, Ciampui, Nkubu, Chogoria and even Embu (more than 100 Km away). She was told there was no disease: the doctors were unable to diagnose her problem. Since she never recovered, she decided to go to a mugao she trusted, accompanied by her husband: after taking a medicine, she felt a bit better. She is now quite satisfied with the treatment of the mugao.

Case 19: Nkima

Nkima is a 45 year old illiterate woman of Ukuuji clan married in Kamurige. She started having severe headaches long ago when she had two children, and it never stopped. When suffering, she feels very tired and cannot even sleep or work properly. She first went to the hospital but she did not recover. Then she turned to the agao. First she went to two famous aringia (Kajira and Mukwaiti) who told her that the cause of the illness were mpingo (a type of sorcery) and mugiro (death impurity).She

was then treated by three agao and also her nyambura was blessed by a diviner. Although her headache has not stopped, she is happy with the treatment received by agao because she was afraid of death: she is just happy to be alive.

Case 20: Nkathe

Nkathe is an elder, about 75 years old, of Kamurige clan living in Kariekajeru. Last year he had a dislocation of the legs so that became swollen: they are still paining him and he is now unable to walk. He first went to Kamanyaki dispensary where he was given three injections and recovered slightly. Thereafter he decided to consult a muringia: he sent his son to Kajira and Mukwaiti for divination, because he could not stand up. They told him that he was bewitched. Mugao Nkoru came to his home to treat him. He recovered a bit, but after a short time his legs became swollen again. The mugao did not treat him completely because he did not have the goat for the ritual. Now he looks resigned to his condition; he says 'Let that illness push me the way it wants: because there was nothing to do'.

Case 21: Kagondu

Kagondu is an elderly woman, 55 years old, of Kamurige clan, married in Igoro and living in Kariekajeru. More than a year ago her hut fell in when she was inside, hurting her: since then, she is suffering from backache, dizziness, headache, joint pains and diarrhoea mixed with blood. She has become very thin and weak. Her relatives have met three times to decide what was to be done for her: the first time they decided to send her to Kamanyaki dispensary. She went but there was no improvement. The second time they decided to consult a muringia: her mother was sent to two different aringia. She was told it was urogi (bewitchment). So she was directed to a mugao who treated her with no success. The relatives then met for the third time and decided to call another, better mugao. She went to Nkoru and after that recovered a bit. Finally, the relatives decided to move her home to another place since they believed the hut was bewitched.She is contented with the treatment received from the second mugao; but she is now trying to go to a hospital.

Case 22: Gakunyi

Gakunyi, a 50 year old woman of Kamurige clan married in Igoro, lives in Kariekajeru. Three years ago she started suffering from backache, chest and knee pains. She also had a miscarriage. When the pains are very strong she cannot even walk. She was taken to Kamanyaki dispensary where she was given tablets but never recovered. Her problem keeps on recurring. She has

never gone to a mugao because, she says, her Christian faith (she is Pentecostal) does not allow her to do it.

Case 23: Chianjoka

Chianjoka is a 23 year old woman of Kanjogu clan who is living in Kariekajeru; she attended Standard III. She got married in 1978 in Kamurige clan but in January 1986 divorced because of barrenness. Her menstruation is regular, although accompanied by severe pains and stomach ache. She went to Ishiara and later to Nkubu hospitals in 1980: she was examined and told that the veins caused the problem during the monthly period. She was told to return for treatment but she had no money. One day I met her at Gauki's home (a famous muringia) whose husband Kabete (who was a mugao) was treating her for Kibitana (sexual impurity). The parents brought her there because they were convinced her problem was caused by losing her nyambura (good luck).

Case 24: Karea

Karea is a 26 year old woman married in Muruguru clan and living in Kariekajeru; she attended Standard IV. After her first-born in 1980, she started feeling sharp pains in the chest and backache: since then she has not been pregnant any more. She first went to Kamanyaki and Gatunga dispensaries: she had a stool examination with negative result. She then went to Nkubu hospital and even there was examined with negative results. Recently her husband was told by his mother to go to a muringia: he went to Mukwaiti and the result was mpingo. I met Grace during the treatment of mugao Nkoru at her home: the rituals lasted two days.

Case 25: Jevina

Jevina, a 24 year old woman of Kathoga clan married in Muruguru, is living in Kariekajeru; she has attended Standard II. She got married in 1977 and in 1978 had a child. Since then, no others were born. Her menstruation is regular but with sharp backache. She went to Nkubu hospital in March 1985: she was treated together with the husband but when they went back for a check-up, the doctor was absent. Thereafter her mother-in-law directed her to a muringia for divination; the husband chose the muringia and when they went the result was rurigi (a type of sorcery) and Kibitana (sexual impurity). I met Jevina together with her husband at mugao Kigwato's home during the treatment: they were directed there by the mother-in-law because Kigwato was her step-father . She now hopes to have a child after the mugao's treatment.

Case 26: Gaichu

Gaichu is an elder 55 years old, of Kamurige clan living in Kariekajeru. Some years ago he started feeling pain in the testicles and penis and then realized he had become impotent. So he started going to many hospitals and dispensaries: Ishiara, Nkubu, Chogoria, Chiampiu, Kathwana, until he decided he was wasting his money without getting well. Therefore he turned to Tharaka medicine (Ugao): he sent his wife to two aringia and the result was mpingo and kirumi. Even his father-in-law went for divination some days ago. He was then treated by many agao, at least seven: but only one seemed to have partial success. M'Mioro from Thagichu made him able to ejaculate, although without any erection. But his genitals are still paining him. He still strongly believes that agao are the only ones who can help him.

Case 27: Karigi

Karigi is a 25 year old woman of Igoro clan married in Kamurige and living in Kariekajeru; she is illiterate. During the last weeks she started suffering from backache and diarrhoea with blood. She went to Kamanyaki dispensary and received some medicines which only reduced the diarrhoea. She then sent her mother to muringia Mukwaiti for divination: she was told it was urogi. Mugao Nkoru was called: he came and treated her together with her children. After that she has not felt pain again.

Case 28: Ntue

Ntue, an elder about 50 years old of Kagunda clan, is living in Kariekajeru. Since six years ago his left arm started paining him a lot and now he cannot even hold anything. He first sent the son of his sister to five different aringia. The result was always the same: urogi. He was then treated by eight different agao together with his wife: but he could not see any improvement.He therefore concluded it was not a matter for them; he went to Nkubu, Meru and Chogoria hospitals, but even there was not healed.Recently, he has also called a kiroria (prophet) who came to his home and prayed for him together with his wife. Now he thinks that his arm problem is probably God's will: so there is nothing to do. However, he still would like to go to a hospital for x-ray to check 'if there is a broken bone inside'.

Case 29: Karemi

Karemi, a 23 year old woman of Nyaga clan married in Gankina, is living in Kariekajeru; she attended Standard III. In March 1986 she started suffering from stomach ache, backache and dizziness. In May she became seriously ill: she first went to

Matiri dispensary and was given tablets, but she did not improve. So she decided to go to Kajuki dispensary where she received an injection, but with no result. Afterward, she sent her mother to a muringia who told her that she was bewitched: there was sorcery in the home. Then she was treated by her father who is a mugao ; even the father divined the same result. After the treatment, the father went to her husband's home and said that, since she is very ill, she must be taken to a hospital. If she is not taken there, and dies at home, the in-law should pay him. The husband agreed to the request. In Nkubu hospital she stayed for some weeks until she recovered, but her disease was not diagnosed. She is very happy with the treatment she received because she has recovered, while the father removed the sorcery from her home.

Case 30: Kaura

Kaura, a 35 year old woman of Kathoga clan living in Kiamairi (Kibuka), has attended Standard I. She is barren, and because of this problem she has married and divorced three times.She stayed with the first husband for three years and she was treated by many agao when she realized she was unable to get a child. When the father-in-law died and the husband did not 'cleanse rukuu' (ritual coitus to be performed after the death of a relative in the homestead) with her, but he preferred to go to Chiakariga for prostitutes; he also started ridiculing her telling her to go away from his home because she was barren. The husband contracted a venereal disease with prostitutes and it was transmitted to his wife when he came back home. The wife was treated in Chiakariga Health Centre and then left her husband. After staying at her father's home for three months, she went to Mombasa with another man who had promised to help her. She went to Makandare Hospital in Mombasa and there she had an x-ray and was treated. She also went to an Atinku healer there who performed a ritual to counteract bewitchment. When the first husband came to call on her in Mombasa,they went back together to Tharaka to discuss their matter in the Court: they divorced. Then she stayed with the second husband for nine months, until her mother-in-law started saying that they would not pay any dowry for a woman who is not giving birth: after a violent quarrel with the husband, she went back home. After going for some time to Igoji in the highlands to earn money, when she came back she started staying with a third man who had promised to send her to the hospital when he got the cotton money. She stayed with him for a year but he never sent her to the hospital; then her mother came to her house with two agao to treat her. One of them was Mangoro who, after his treatment, promised to help her. She followed Mangoro, abandoning the third husband. It was at mugao's home that I met her during a ritual of kio he was performing for her. I later accompanied the two of them to Nkubu hospital where she was examined and treated for venereal disease. She is now hoping to get a child by Mangoro, who has taken her as a second wife.

APPENDIX D

A Three-stages Strategy of Interprofessional Cooperation

The process of cooperation at the interprofessional level - that is, between biomedical and indigenous health practitioners - was implemented in the Tharaka Rural Health Care Programme following a three-stages strategy: the first lasted about six months (July-December 1985). We could term it as a 'preliminary study', during which each side of the relationship was brought into contact with the other and could size each other up. The biomedical personnel, in particular, were more dubious and sceptical in their attitudes: even though the interest in the problem was good (since its practical implications and benefits were perceived), the doctors of Nkubu Hospital (at the time still represented by expatriate volunteers sent by the Italian NGO C.U.A.M.M.) required us to limit this first period to a purely cognitive work, with an exchange of reciprocal information with Tharaka healers. What was most important, the doctors showed a real willingness to know who the agao were, what they did and how they practised: in this way they tried to get over their Western 'witch-doctor' stereotypes. They agreed that the first step should have been the definition of a 'common language' with the healers, in order to properly understand one another. To achieve this, a preliminary basis of knowledge was requested as a solid ground for any further work. This included also a theoretical background, with reference to the current medical and anthropological literature on the subject: four seminars were held with the doctors to study and discuss deeply the matter, with particular attention to previous African and Asian experimentations of integration. It was acknowledged that the differences of language and approach between biomedical and social sciences was a problem not to be overlooked; and that an adequate level of interaction between the two could be achieved only as a result of an improved level of inter-communication.

After these preliminaries, it was finally possible to start a series of five meetings between the doctors directly involved in Tharaka area (three out of six) and the agao groups already formed (Kithino and Kibuka) or in process of being formed (Kamarandi, Kamanyaki and Chiakariga, a group that failed to be formed). Two of the meetings took place at the dispensaries of Materi and Marebe (where the local nurses also took part); three of them at the usual venues of the agao groups. It is also important to point out that three meetings were attended also by the local authorities (Chief, Subchief, Kanu leader), which ensured their formal support for what was taking place for the first time. During the meetings, there was a general feeling of empathy and readiness to exchange ideas and to look at the different approaches to health problems. The communication flows had certainly two-way direction: none of the people present ever expressed any form of embarrassment or inferiority. The human contact helped to create a climate of

reciprocal respect and interest in learning and understanding something new. Both kinds of practitioners explained their work and the way it was learned: then the doctors were particularly interested in knowing the kind of illnesses the agao claimed to treat, the way they recognized them and their forms of treatment. The difference between ritual therapy and herbal treatment was particularly pointed out: and even the effects of seasonal changes on the efficacy of the herbs was discussed. When asked whether they usually refer their patients to hospitals, most of the agao made it clear that the majority of their patients came from the hospital after not being cured by doctors. In any case, they usually referred their patients to other agao or to hospitals as a last resort. Explicitly asked for their opinion about the possibility of starting some form of cooperation, all the agao enthusiastically agreed with such a proposal; only one old *mugao expressed some* doubts and a certain degree of distrust, justifying his attitude *with his memory of* past colonial experience. Another one raised a disarming *question about the* reason why only now were the white men interested in Ugao, since they had arrived in Kenya so long ago. A proposal was also advanced by the doctor in charge of Nkubu hospital to some agao to come to the hospital and treat patients affected by mental problems: the agao expressed some mental and practical reservations regarding their being unfamiliar with the hospital environment and the fact that the medicinal plants available on the highlands were not the same as those found in semi-arid zones like Tharaka. Moreover, once it was agreed that a small room could be specifically reserved for their work in the hospital and that medicines could have been periodically brought up from Tharaka, the main obstacle mentioned remained the license: the agao were afraid of any sanction (especially in case of mistakes) when outside their home area. The proposal was later dropped due to the opposition of other doctors and to some practical problems.

After these preliminary contacts, a second 'study phase' was planned with the specific purpose to pave the way for the implementation of a well-grounded form of cooperation. It lasted about one year, covering the whole 1986. At the time, there was still no clear idea of what type of cooperation could be the most appropriate, as the proposal of the doctor in charge of the hospital to call some agao to treat mental cases in the institution shows. Therefore, there was a real need to deepen the knowledge of the Ugao and the actual and possible forms of its relationship with biomedical services. For this purpose, the first step was to select some priorities on which to focus the work. These were biomedically defined by the doctors on the basis of known epidemiological data about the prevalence of diseases in Tharaka (see Appendix B) and were discussed with the researcher and the Tharaka community during meetings with the VHCs of Tunyai and Kamanyaki. The priorities regarded four groups of diseases:

1) malaria, which accounts for about half the morbidity in Tharaka, and is endemic;

2) diarrhoea and intestinal worms, both very frequent in Tharaka (especially among children), with important implications for hygiene and sanitation;

3) infertility, a problem felt as extremely important by Tharaka people (especially women), affecting marital relationship and family planning;

4) sexually transmitted diseases, whose increasing importance and diffusion among Tharaka is proportional to the widening of their cultural contacts.

Since the agao had claimed to be able to treat all these problems, the researcher arranged with the doctors to choose four of the most prominent among them and then follow the diagnostic and therapeutic steps taken by the agao for each of the disease. I was to observe the type of cure practised by each mugao and record all the symbolic actions, spells and objects used during the treatment. Where possible, on invitation of the mugao himself, I was to observe the treatment performed on a real patient; otherwise, I would have to ask the mugao to re-enact the treatment. After that, I was also to interview the actual patients.

The treatment followed in this way were sixteen in all; five of which were actual cases.From the analysis of the recorded data and the field-notes, I set up a check-list, for use in the follow-up interviews with the agao, in order to understand the emic meaning of all the actions, spells, songs, and objects used during the cure, as well as the etiological, therapeutic and classificatory concepts implicit in the cure.

The purpose of this work, which lasted for some months and was planned in cooperation with the doctors, was as follows: 1)to assess the degree of standardization in Ugao practice; 2) to assess the internal (inter-agao) and external (agao-patient) consistency of such practices and of the cognitive aspects involved; 3) to identify the 'areas for intervention', where some form of cooperation was most appropriate and needed; 4) to make an initial, rough, evaluation of the kind of therapeutic effectiveness of Ugao rituals. To do this required two further steps, besides the investigation described above. One was the direct involvement of some doctors in the field-work by their 'working jointly' with agao in treating some clinical cases.This would directly allow us to understand the peculiarities of each medical technique when confronted with the same case: in particular, the way the problem was labelled, classified, diagnosed and treated by each type of practitioner. The study was only partially succesful in five clinical cases, since it proved extremely difficult and time-consuming - once it was established that the 'joint treatment' should not take place at one, artificial site, but should be done in the usual workplace of each; I had to organize the patients, doctors and agao, moving between the dispensary or hospital and the mugao's home. This is where the researcher's role as a cultural broker was also very important, acting as a go-between doctors and agao to ensure acceptance, facilitate relationships, and explain to each the

meaning of what was being performed, in order to make them understand its actual significance and the practical implications. However, practical obstacles made it impossible to continue the project though it proved very interesting: for example, the apparently minor element of a timetable was only partially respected, and caused some problems for doctors engaged in hospital duties. Three out of the five cases were suggested by the agao - three women, all with infertility problems. Two were selected by doctors: a man with a problem of impotence and a woman whose problem it was not possible to properly identify (doctors suspected typhus). The 'Comparative Charts' of the clinical cases (Cf. Chart D.1) represent a synthesis of the resultswork done, with a short description of the kind of interventions practised by each type of practitioner, the setting where they were done and the interactions that took place. Of particular interest were the joint discussions of the cases between the doctors and the agao that took place at the dispensaries of Materi and Marebe in Tharaka. Instead of the superficiality that had characterized the previous encounters during the first phase, these had the actual character of professional meetings, during which all the crucial aspects involved in each case were debated. In spite of the two completely different approaches to the same health problem, with different terminologies, different criteria of relevance, different ways of dealing with them, it was possible to have a common basis for communication and interaction. This seems to confirm the relevance of actors' attitudes in any process of cooperation where behavioural factors are as important as structural ones.

The third step of this second phase involved a working programme jointly conducted by the doctors and the researcher, which lasted about three months. The six doctors were subdivided into three groups, and each worked on one or two of the four selected diseases we mentioned before. Each group, with the support of the researcher, prepared a descriptive medico-anthropological card containing the biomedical approach to the disease at issue (with specific regard to the African context) compared with the indigenous approach followed by Tharaka people and professional Ugao towards the same problem. The description of the latter was based on the research materials collected by the researcher about the sixteen therapeutic treatments examined and the five clinical cases jointly followed by both types of practitioners. The cards were organized (for biomedical purposes) following a schedule for each disease: terminology, definition and classification; clinical aspects (signs and symptoms); etiology; diagnosis; therapy; prognosis; epidemiology, prevention and control; unresolved problems. The results of this work were presented during four seminars held at Nkubu Hospital with the participation of paramedical personnel and a representative of the agao groups. During each seminar, a single medical-anthropological card was examined and discussed; and the operative implication for cooperation were particularly pointed out in details. In this way, the research work was first

Chart D.1 Comparative Charts of Clinical Cases

BIOMEDICINE	THARAKA 'UGAO'
Case 1 Kabogo	
Diagnosis: primary infertility of probable hormonal aetiology. Treatment: admitted to Nkubu Hospital for a week to conduct investigations. No specific treatment given.	Divination: 'Urogi' Treatment: more than 15 agao treated her since 1974 (full details in Case 1 of the thirty illness episodes) with no significant result apart from starting experiencing irregular menstrations.
Case 2 Kayogo	
Diagnosis: secondary infertility of fibroid aetiology. Tratment: the patient was first examined at Marebe dispensary and then admitted to Nkubu Hospital for further investigations. No specific treatment given.	Divination: 'Urogi' Treatment: ritual of 'kurogora' by the mugao Kinyua attended by the doctor in charge of Nkubu Hospital; the case was also discussed between doctors and agao at Marebe dispensary. No significant result.

Case 3 Ciampui	
Diagnosis: secondary infertility of post-gonococcal aetiology Treatment: the patient was first examined in Marebe dispensary and then admitted to Nkubu Hospital for further investigations. Gonorrhoea was detected, and specific treatment given for it.	Divination: 'Mpingo' Treatment: treated by 10 agao; after the last one (Rukungi)she has improved the regularity of her menstruation (illness episode n.2). Her case was discussed between doctors and agao at Marebe dispensary.
Case 4 Karemi	
Diagnosis: pyrexia of unknown origin. Treatment: the patient was first treated at Materi dispensary for malaria; then she was admitted to Nkubu Hospital where she remained for a month in serious condition. Then she has recovered.	Divination: 'Urogi' Treatment: the mugao performed kurogora for her and then she sent her to Nkubu Hospital(illness episode n.29). Her case was discussed between doctors and agao at Materi dispensary.
Case 5 Ndeke	
Diagnosis: impotence of probable psychosomatic origin. Treatment: no specific treatment given; referred to the agao.	Divination: 'Mugiro' and 'Urogi'. Treatment: rituals of mpingo, kio, rurigi and mugiro performed by M'Mburuki, Kinyua and Rukungi (cf. Ch.4). The patient declared he had recovered.

translated into a biomedically useful tool (the cards); and then discussed as a pivot for implementing a system of cooperation. Moderate interest with some scepticism was shown by the paramedical personnel, whereas the reaction of the agao was enthusiastic and extremely cooperative. They were proud of the fact that, for the first time, the Ugao approach was put 'on the same level' with biomedicine; and they totally agreed on the way their work was presented. This round of seminars represented a landmark for beginning the system as sketched in the cards.

During 1986, two meetings were held at Nkubu Hospital: one on May, 29th on the history of traditional medicine in Kenya and the possibility of cooperation with biomedicine; and the other on December 18th on the role of TBAs in Kenya's health care delivery system , with the presentation of some examples of training of TBAs in Primary Health Care programmes. Both were run by two scholars of the University of Nairobi (Dr.Nyamwaya and Dr. Kimani) involved in the Project as consultants, and were attended by Nkubu hospital staff, the students of the Community Nursing School, and by a representative from the other Meru District hospitals (Chogoria, Maua and Meru) and from the Tharaka agao groups.

Finally, the whole project was presented and discussed with students of the Faculty of Medicine, Nairobi University, on June 25th, 1987. The seminar was jointly organized by C.U.A.M.M., the University of Bologna, with the hosting Department of Community Health under the patronage of the Italian Cultural Institute of Nairobi. Besides the researchers involved, two Tharaka agao and two ajukia also attended: their speeches outlining their activities were carefully listened to by the students who asked them many questions. This unique chance of exchanging professional knowledge for the first time in an academic venue was particularly stressed by Prof. Gekonyo, chairman of the Department of Communiy Health; and even Prof. Pamba, Dean of the Faculty of Medicine, considered it 'a rare opportunity where traditional and hospital specialists come together'. Tharaka health practitioners, on their side, were obviously very proud and enthusiastic about what they had attended.

On the basis ot the results obtained during the 'study phase', it was possible to start implementing the forms of cooperation of the type sketched. This third 'implementation stage' started from the beginning of 1987 onwards. In 1992 I conducted a follow up study to evaluate the functioning and the impact of the work done after five years, a period deemed sufficient for a first assessment. I particularly focused my attention on the two main aspects of the cooperation system as defined: the interprofessional workshops and the referral system.

Since 1987, the whole group of doctors and the midwife (a Kenyan) of Nkubu Hospital were actively involved in a series of intensive workshops with the agao and the ajukia in Tharaka with the purpose of deepening some aspects which needed further investigation and settling the last details for beginning a referral system of the type suggested in the medical-anthropological cards. Using a check-list containing a series of

questions about some specific problems, the doctors and the midwife for the first time met the traditional health practioners in their own setting without the brokerage of the anthropologist: only the former research assistant (now that he had become 'Public Health Field Assistant' of Nkubu Hospital after a short training course at AMREF in Nairobi) was present. During such workshops, the last operative details for the implementation of the referral system were arranged. This work of on-going evaluation and 'tuning' of the system also continued in the following years with the support of the two consultants from Nairobi University and AMREF.

In 1988 the hospital midwife was sent to Nairobi for a specific course on TBA training in order to acquire specific skills on the subject; while the Public Health Doctor continued the workshops in Tharaka with the agao groups. They were mostly aimed to further investigate some aspects of those illnesses where a supplementary relationship was typically present between the two types of medicine: such as in the case of malaria, diarrhoea and intestinal worms. Since they acknowledged the importance of subjects like hygiene, sanitation and nutrition in such cases, the agao requested specific further training on them. The result of these field meetings was thus the arrangement of another series of workshops at Nkubu Hospital with the aim of improving the agao's skills on such matters. The workshops were held at more or less regular quarterly intervals during the following two years. Transport and lunch were offered to the agao by the hospital.

In March 1989, the first workshop was about 'Group work': it was attended by the Public Health Doctor, the Public Health Field Assistant and thirteen agao, *five from Kibuka, five from* Kithino and three from Kamanyaki groups. The agao's concept of group, their perception of its advantages and problems, the way they would like to improve it were the main subjects. The discussion was lively and the agao felt the topic very useful for their purposes. In the following workshops, the focus shifted to public health topics: specifically, on personal hygiene and home sanitation in June 1989; on nutrition, malnutrition and food storage in August; on prevention of transmitted diseases in January 1990 (with the participation of twenty-five agao, two fron Kibuka, twelve from Muthitwa, five from Kamanyaki and six from Kithino); on sexually transmitted diseases, including AIDS, on May 1990.

After this second round of workshops had ended, in July 1990 a meeting of the Public Health Committee was held at Nkubu Hospital: the chairmen of the now five agao groups were also invited, together with a representative from the other district hospitals, from AMREF and the officer in charge of the Eastern Province branch of the National Association of Herbalists (Waganga wa Miti Shamba). In the meeting, it was decided to extend the referral system to the other district hospitals, too: this was because most of the agao's patients had complained that when they went to hospitals other than Nkubu, the referral card was not recognized. Further, the failure of a final report by KEMRI on pharmacological tests perfomed on the agao's samples was raised and discussed, together with the issue of a licence for

those who had not yet got one. The national association officer promised to solve the former while the AMREF representative promised to raise the latter at the Ministry of Health headquarters in Nairobi.

In conclusion, I would argue that the workshops have proved to be a very useful tool for further advancing the cooperation process previously started: their two-way communication allowed an exchange of information, opinions and attitudes that produced a real meeting of minds among the people present. Even though the asymmetry which is the consequence of biomedical dominance was certainly not totally overcome (a certain difficulty in expressing themselves, out of a feeling of inferiority, has remained among the agao) a big step forward in this direction has been taken.

The other focus of my evaluation, besides the workshops, was the referral system. This started to be implemented during the last months of 1987, after the intensive series of workshops held by doctors and midwife with agao and ajukia. We shall consider here only the first kind of referral for our topic. The Public Health Doctor of Nkubu had prepared two specific cards (Appendix G): one for both the agao and the doctors to be used for referring the patients, and the second one for the doctors only, containing a comparison of the diagnostic and therapeutic procedures used by both types of practitioners. The former type of card was issued in four different colours to each of the agao groups, as arranged with them, in order to recognize immediately to which group the referring mugao belonged. Unfortunately, the documentation I collected is very partial, since most of these cards got lost: I was able to find only 36 of them in the hospital, but oral testimonies by both agao and doctors claimed many more cases. Out of the 36 cases found, 14 were referred from Muthitwa group's agao, 9 from Kithino, 8 from Kibuka and 5 from Kamanyaki. No case resulted referred from Kamarandi group (but group members denied this). The time period covered is about three years, from February 1988 to December 1990: after that, the cards were no longer collected (even though hospital nurses testified that patients continued to be referred with them), since the Public Health Doctor had left.

In tab.D.1 the cases referred are summarized according to the claimed symptoms or their diagnosis when available. Even if it is extremely difficult to venture a hypothesis about them given the limited number available, by examining the cards the impression is that, with the exception of few cases being referred because they were deemed to be within exclusive competence of biomedicine (e.g., a hand fracture, anaemia, cancer), most of the cases were referred after the mugao's treatment failed. Since the majority are cases of diagnosed malaria (7) or were suspected as being such (13 cases of joint-pains/body ache and 4 cases of dache), I would argue that the system worked mainly as a supplement, to make for the failure of indigenous treatment, and only partially as a complement, once the proper mugao's treatment had been performed (some cards mention urogi, gendaga and kirumi). It appears extremely

Tab.D.1 Cases of patients referred by agao to Nkubu Hospital

symptoms/diagnosis	n.
joint pains and body generally aching	13
malaria	7
headache	4
skin problems	3
leg problems	2
eye problem	1
intestinal worms	1
cancer	1
hand fracture	1
infertility	1
measles	1
anaemia	1
Total cases	36

significant that no cases of mental problems were referred.

For an overall evaluation of the system, it is perhaps better to rely upon the oral testimonies I collected. A first problem was represented by patients'attitudes. Not all of them were willing to go to Nkubu Hospital: some of them, especially in the Kithino area, were used to going to the nearer hospital at Chogoria. But there, the referral card was not recognized until 1990: this created some misunderstandings. Even in Nkubu Hospital, not all the personnel at the Out-Patient Department were aware of the system, or, even when aware, were sympathetic towards the patient. This explains the problem raised by the agao of the Kamarandi group about the unwillingness of some of their patients, when referred to the hospital, to say openly that they had been treated by a mugao. Moreover, with only one referral

point in the hospital (the Public Health Doctor), whenever he was absent or after he had left it was difficult to keep the system functioning. Besides, it was necessary to undo referred patients' expectations about a possible discount on hospital fees.

Other difficulties, apart from patients' and nurses' attitudes, were of a practical kind: when most of the cards for the agao ended in 1990, nobody replaced them once the Public Health Doctor had left. The agao solved it by exchanging the remaining ones among themselves in the groups: but in most cases they were not enough. In 1992 a new stock of cards was distributed to continue the system. Besides, since many agao were illiterate, the cards were filled in by their educated sons, who did not know the technical terms used for certain illnesses. Then, there was the problem of travel for a patient referred from a group like Kamanyaki living in an area not served by public transport: in most cases it put the mugao in the uncomfortable position of having to decide whether to go as far as possible with his treatment, or to refer the patient as soon as he realized his treatment was ineffective.

Finally, there is a series of problems of a more general kind, involving organizational and cultural options. Some groups of agao (Kithino and Kamarandi) complained reasonably that no patient was ever referred to them by hospital doctors, as had been agreed: I sensed a feeling that, at least partially, their expectations of full collaboration had been betrayed. The absence of such bi-directionality in the system - which would have undoubtedly pleased the agao - probably did not cancel out in their mind the suspicion that they were being simply robbed of their patients by the system. Besides this important point, another fundamental problem was that , for a series of organizational and practical reasons, it was in most cases impossible for the doctors to hold a full joint discussion with the agao about each case referred as had been planned: only a few cases were occasionally discussed by the Public Health Doctor during his meetings with the agao. The expiry of the sponsorship supporting the researcher and of two Kenyan consultants after 1990 also made it impossible to make a more general evaluation of the implementation stage until my field visit in 1992. During the follow-up, I could assess that the referral had generally worked, though not always as planned and with some shortcomings: most of these can be ascribed to an underestimation of the importance of the role of paramedical personnel. In spite of the work with the nurses (seminars at the hospital, attendance to workshops with agao in Tharaka by the nurses of the dispensaries, etc.) not all the personnel involved had been adequately prepared, as the problems raised by some patients show. This suggested some corrections to the model regarding these points, in order to make its implementation more effective.

APPENDIX E

List of Tharaka Medicinal Plants

The following list is the result of a collection of medicinal plants I brought from Tharaka to the University Herbarium of Nairobi for botanical identification: they all belong to Angiosperms and they are subdivided into 28 families, 24 of which belong to Dicotyledons and 4 to Monocotyledons class. Those plants whose identification proved impossible are not reported here: they were many. For further details on East Africa medicinal plants, see Kokwaro (1976).

VERNACULAR NAME	BOTANICAL EQUIVALENT	FAMILY	PROBLEM TREATED
muthungucha	Blepharis linariifolia	Acanthaceae	poisonous
mueria	Aerva persica	Amaranthaceae	abdominal pains
muringamaria	Kanahia laniflora	Asclepiadaceae	mugiro
mubobua	Balanites glabra	Balanitaceae	coughs
ciang'ongo	Sarcophite piriei	Balanophoraceae	dysentery and snake bites
muchaguca	Commiphora sp.	Burseraceae	wounds and scabies
mware	Boscia Angustipholia	Capparaceae	kirumi and kibitana
muuti	Aspilia pluriseta	Compositae	wounds and eye problems
ng'ondu	Notonia petrae	Compositae	kibitana
muremangige	Adenium glaucens	Euphorbiaceae	poisonous
mukinduri	Croton megalocarpus	Euphorbiaceae	urogi
ndaru	Euphorbia tirucalli	Euphorbiaceae	emetic and sterility
mwatha	Euphorbia saxorum	Euphorbiaceae	poisonous
mbariki	Ricinus communis	Euphorniaceae	intestinal worms
muretha	Sphirostachus veneniphera	Euphorbiaceae	poisonous
makuri	Ocimum Kilimandscharicum	Labiatae	malaria
mworu	Plectranthus sylvestris	Labiatae	abdominal pains

njuthi	Caesalpinia volkensii	Leguminosae Caesalpinioideae	malaria and intest.worm
mugambu	Acacia drepanolobium	Leguminosae Mimosoideae	sore throat and diuretic
mwarwa	Albizia anthelmintica	Leguminosae Mimosoideae	emetic and purgative
mukina	Indigofera arrecta	Leguminosae Papilionoideae	stomach ache
muthoroko	Vigna unguiculata	Leguminosae Papilionoideae	poisonous
mwea	Loranthus uluguruense	Loranthaceae	gendaga and kioria
mwegere	Hibiscus fuscus	Malvaceae	wounds and poisoning
mukau	Melia volkensii	Meliaceae	snake bites
mukuyu	Ficus capensis	Moraceae	back pains
mugumo	Ficus stuhlmanii	Moraceae	mugiro and gendaga
muroroma	Ximenia americana	Olacaceae	cough
kinoria	Adenia volkensii	Passifloraceae	poisonous
mwonkia	Plumbago zeylanica	Plumbaginaceae	poisonous
kamama	Portulacca kermesiana	Portulacaceae	kioria
muguchua	Zanthoxilum chalibeum	Rutaceae	malaria
murangare	Zanthoxilum usambarensis	Rutaceae	malaria
mutagata	Harrisonia abyssinica	Simaroubaceae	malaria
mutongu	Solanum incanum	Solanaceae	stomach ache emetic
mukenia	Lantana trifolia	Verbenaceae	rheumatism indigestion
mukanyanga	Cissus rotundifolia	Vitaceae	skin problems
ikongo	Agave americana	Agavaceae	wounds
ndago	Cyperus articulatus	Cyperaceae	worms and malaria
mutharangi	Heteropogun contortus	Gramineae	poisonous
mukobo	Ensete ventricosu	Musaceae	liver troubles miscarriage

APPENDIX F

KEMRI Pharmacological Research

Collaboration with the Kenya Medical Research Institute (KEMRI) was requested for the purpose of investigating the pharmacological principles contained in Tharaka herbal medicine and evaluating their effectiveness from a clinical point of view. The Institute was charged by the Kenya Government with the responsibility of evaluating traditional medicine; for this purpose a specific branch, the 'Traditional Medicine and Drugs Research Centre', was established within the Institute.

Since KEMRI research investigators required preliminary information about the healers, the illnesses they claimed to treat, the medicinal plants they used (and which parts), how they collected and prepared them, the dosages used and storage conditions, there was a preliminary exchange of information between the anthropologist and Dr.Kofi, the director of the KEMRI branch. Then two field visits were planned and implemented in 1986 to allow the researchers to contact directly the practitioners and collect medicines and plants on the spot. As a result, some medicinal plants and medicines prepared by the healers were to be chosen and collected for identification according to the botanical classification, and investigated in KEMRI's chemical-pharmacological laboratories.

The results were to be presented and discussed with both the traditional and the modern health practitioners involved in the Tharaka programme: particularly, some suggestions were expected about ways of improving preparation, dosage and safe storage of herbal medicines. In this way, the aim was to involve pharmacologists in the promotion and development of Tharaka indigenous medicine and in its cooperation with biomedical practitioners.

However, the work was never carried out as planned by KEMRI: what follows is the preliminary report received after the first field trip. After this, nothing more was ever produced by KEMRI.

KENYA MEDICAL RESEARCH INSTITUTE

Address all correspondence
to Director
Telephone: 334031
Telegrams: DRUGRES

Our Ref:

Your Ref:

Traditional Medicines and
Drugs Research Centre,
P.O. Box 54840,
Nairobi, Kenya.

Date ...12th...May...., 19...86

Dr. Guido Giarelli
Nkubu Hospital
P.O. Box 205
MERU

Dear Dr. Giarelli,

THARAKA PROJECT.

I refer to our earlier discussions with you and Professor Volpini in my office. In those discussions it was understood that the participation in your project would involve the evaluation of one or two traditional medicines that you would identify as of particular significance to your project. It was in this context that your proposal was forwarded to the Director of KEMRI for approval.

During our visit to Meru in the first week of April, we carried out a preliminary survey of some traditional medicinemen at Tharaka which you had previously identified. Below is a summary of what I gathered. However, in view of the recent developments, I would like to meet you in my office on May, 1986 in order to set out a clearer understanding of the KEMRI involvement in your project. This is particularly important because no further work on your aspect of the project will be carried out until this discussion is held.

Now, from the interviews at Tharaka we found the following:

Four medicinemen were interviewed, namely:

1. Joseph Gichugu
2. Samuel Kinyua
3. M'Mburuki Muthia
4. Rukungi Mungania.

Joseph Gichugu: This man claimed the ability to treat the following indications: measles, snake bite, malaria, Fresh-wounds, secondary ammenorrhoea, threatened abortion, worm infestation and madness. He provided a sample of a drug plant for use as anthelmintic. He also presented only one of three drug plant samples that he claimed to use against snake bite. He was unable to provide the other samples, nor was he able to give the identities of the plants.

../2

Considering the fact that this was a first visit, it is to be expected that a more detailed information will be obtained in subsequent visits. Both the anthelmintic plant sample and the snake bite samples contained alkaloids. But no further information can be given until the other component samples of the snake bite medicine can be obtained and more information on all the samples can be gathered.

Samuel Kinyua, M'Mburuki Muthia and Rukungi Mungania: The three men were interviewed together at one sitting. They also claimed their ability to treat diseases similar to those of the previous medicineman. They provided for analytical evaluation the following drug plant samples:

i) Medicine for Malaria: This consisted of roots from 4 different plants, to be boiled together and taken orally. All the 4 were found to be alkaloidal plants and the toxicity of such a preparation will need to be established.

ii) Medicine for skin rashes: This is prepared from two different roots in combination. A decoction is drank to remove the rashes. These are also alkaloidal plants.

iii) Medicine for Bloody stools and Painful Ribs: This was a plant root for preparing an oral medication. It contained mainly plant phenolics.

General comments: This was a first visit to the 4 medicinemen. Therefore, an evaluation of the medicinemen and their medicines would be premature. Further visits are necessary.

I look forward to meeting you on 19th May. Please remember to let me have the copy of your research licence from the Office of the President, as you had promised.

Yours very sincerely,

DR. W.M. KOFI-TSEKPO
DIRECTOR, TRADITIONAL MEDICINES AND DRUGS RESEARCH CENTRE

APPENDIX G

Referral Cards

REFERRAL CARD

TARIKI _____
(DATE)

RIITWA RIA MUGAC _____
(T.H.'S NAME

_____

GIKUNDI GIAKE _____
(PATIENT'S NAME)

_____

KURA AJITUE _____
(SYMPTOMS)

_____

_____

_____

_____

I MURIMO _____
(DISEASE)

_____

IKI KIATHIMA UMWIRA ATHI CHIBITARI _____
(REASONS FOR REFERRAL) _____

_____

_____

_____

PUBLIC HEALTH DEPARTMENT

CONSOLATA HOSPITAL

NKUBU.

REGISTRATION SCHEDULE FOR THE PATIENTS REFERRED TO THE MODERN DOCTORS BY THE TRADITIONAL HEALERS AND VICEVERSA.

N _____ DATE _____

PATIENT'S NAME _____ AGE _____ SEX _____

DIVISION _____ LOCATION _____ SUB LOC _____

PART I TRADITIONAL MEDICINE

T.H. NAME _____ GROUP _____

I) - TRADITIONAL DIAGNOSIS _____

2) - TRADITIONAL TREATMENT _____

3) - TRADITIONAL FOLLOW UP _____

4) - PATIENT'S MOTIVATIONS FOR ATTENDING T.H. _____

_____

5) + MOTIVATIONS FOR REFERRAL _____

_____

PART 2 MODERN MEDICINE

I) - PAST MED. HISTORY AND FAMILY HYSTORY _____

_____

2) - PRESENT MEDICAL HISTORY _____

_____

3) - LABORATORY INVESTIGATIONS _____

_____

4) DIAGNOSIS _____

5) - TREATMENT _____

_____

6) - EFFECT OF THE TREATMENT _____

7) - FOLLOW UP _____

_____

8) - MOTIVATIONS FOR REFERRAL _____

_____

APPENDIX H

Certificate of 'Practice of Herbal Medicine'

MINISTRY OF HEALTH

Telegrams: "MINHEALTH", Nairobi
Telephone: Nairobi 720030
When replying please quote
Ref. No. MHS/17/4/97 Vol. III/137
and date

AFYA HOUSE
CATHEDRAL ROAD
P.O. Box 30016, NAIROBI

20th May, 87

TO WHOM IT MAY CONCERN

PRACTICE OF HERBAL MEDICINE

NAME: MANDUYO KANYOORO

ADDRESS: P.O. CHIAKARIGA

PREMISES & PLOT NO CHIAKARIGA

IDENTITY CARD NO. 2469396/65

Subject to compliance with any other Laws or Regulations made by the Government of Kenya, Nairobi City Commission, or any other Township Council, the Ministry of Health has no objection to the above named person engaging in the practice of Herbal Medicine according to the general accepted African norms in such practice and provided further that the material used in such practice shall have been known not to be toxic in the usual portions recommended or administered in the form of injection. Further, you are required to submit such material for Analysis at Government Research institutions as may be necessary.

For: B.K. Njue (Mrs.)
DIRECTOR OF MEDICAL SERVICES

APPENDIX I

History of the 'Aqao' Groups

The autonomous process of professional development began in South Tharaka Location in 1985 and little by little gave rise to six small groups during the following eight years: Kitheno, Kibuka, Muthitwa, Kamarandi, Kamanyaki and Rwakiemb'ea (this last one is in Central Tharaka Location). I shall give below a short history of the development of each group based on the minutes of the meetings they more or less regularly held during the period 1985-92, on the participant observation of some of them, and on ethnographic interviews with the chairman of each group.

KITHINO GROUP

It was the first group, composed by five agao who took the oath on 9th September 1985: Njoeli Muchiri, Kigwato M'Mukindia, Kiaya Kanyoro, Mugambi Mwarania and Makembo M'Rimberia. Their meeting place was first in Kitheno area, near Marebe Secondary School. The first phase of the group (about a year and a half) is marked by a series of troubled relationships among the group's members and, particularly, between them and their leader Njoeli Muchiri. His strongly individualistic style of chairmanship was not appreciated by the other agao, who felt scorned by him: Njoeli's behaviour seemed to stimulate the fight for supremacy within the group. This was anything but new, since competition among agao has always been stiff; and cooperation of more than two of them was unheard of before. Even the relationship with the other rising group, Kibuka, soon degenerated: they accused the other group, and particularly its leader Muchiri Kirimu, of dishonest behaviour towards themselves. It was soon clear that the leaders of the two groups were trying to outdo each other and claim ultimate leadership of Tharaka agao. In this initial stage, beyond this still strong feeling of mistrust among the agao, there was also an inappropriate understanding of the idea of group formation: the fact that the leader Njoeli was already known to Volpini in the 1960s (Volpini,1978:56), seemed to create a lot of wrong expectations vis a vis biomedical personnel. Most of the agao tended to think that they would have to practise together on the model of a modern clinic where they would be equipped, dressed in uniforms, and probably paid a salary by the government or the mission.

These and other misconceptions took quite a bit of time to be cleared up in the agao's minds: nevertheless, the early idea of charity continued to hinder the development of a self-reliant spirit. Things improved a lot when, in 1987, the group decided to remove Njoeli Muchiri from leadership, replacing him with Kigwato, an old mugao: after this, the former leader refused to continue to attend meetings and, after a while , was expelled from the group. The new style of chairmanship, particularly

active and concerned to create strong group feeling, was greatly appreciated by the members. The new leader had a faithful adviser in the elected vice-chairman, Kiaya: this 'dual leadership' ensured a long period of stability to the group. In the meanwhile, rumours about what was taking place started to spread: and the group, in few months, found its members had more than doubled. This suggested the group move to a new venue in Kamathuri, where they had been given a piece of land by a group member (Kiaya). This gave rise to the idea of building a more permanent meeting-place: they decided to build a gaaru, a circular hut on the traditional model that was used for circumcised warriors. The gaaru was built up by the communal labour of the group's members and in May 1987 it was ready and inaugurated by a feast with a goat offered by the chairman and vice-chairman. This immediately fostered the process of developing more defined internal regulations on how to use the gaaru: it was decided that nobody would be allowed to treat people in the centre alone. Each member should get a partner with whom, during non-meeting days, he could use the gaaru for treating patients. This 'collaborative working style' was clearly suggested by the Chairman as a replica of his professional relationship with Kiaya.

It was decided to fence the gaaru; a path was cleared to the main road by members'communal labour, and a signboard was put up: so as to make it easier for any visitor to reach the place. In the meantime, requests for joining up more new members led the group to discuss the general issue and decide to restrict access: apart from the usual goat to be brought for the oath as before, the candidate should pay a registration fee of 200 KShs: this did not prevent the number of members rising to seventeen. The group's strong power of attraction can be explained by two facts that marked the group's life during this period: the public registration of the group as a 'self-development group' and the issue of individual certificates of herbal practice by the Ministry of Health of Kenya (see Chapter 10). Both these elements strongly impressed other agao, confirming in their minds that the new idea of the group formation was a success. This also created a sort of 'divide' between the earliest licensed group members and the other agao, who had joined the group later. The former started thinking of themselvers as 'superior' to the others, because of their acquired legitimated status. This division started becoming a real problem in the next phase, when the other agao never got the certificates they expected (because of a change of policy in the Ministry of Health) and did not attend group meetings anymore because they felt they had been cheated.

On the other hand, the licensed members (less than half of the group) greatly increased their work, getting many patients from far away and travelling freely to different areas: one of them (Kiaya) even opened a 'clinic' in the highlands, just opposite Nkubu Hospital. This also created a problem of conflict between individual practice and group loyalty: some of the members tended to disappear for long periods to carry on their work, without attending group meetings anymore. This and other problems that affected the internal life of the group were solved by the establishment of a series of strict regulations regarding

members' behaviour. It was decided that late or absent members should be fined 20 KShs each time; and that drunk members would not be allowed to attend any group meeting. Members who did not regularly attended communal labour were to be seriously reprimended; and should they continue to do so, they should also pay the fine. A member who was absent for quite some time also received a letter of reprimand from the chairman, to which he had to reply by publicly explaining himself during a meeting. They decided to pass a resolution requiring members inform the chairman in advance in case of non-attendance at a group meeting. Furthermore, the newly established treasury (required by the group's registration) was discussed and it was decided to keep a reserve for any eventual group need (transport, etc.), since 'there is no group without some contribution' (the chairman). The secretary (the other newly appointed official along with the treasurer) should keep minutes of their meetings and record the number of patients every mugao has treated or referred to the hospital.

Even more significant were the changes which the new group stimulated in traditional work practice. Apart from what has already been said about the gaaru, agao started reporting their most difficult cases during their meetings and exchanging their knowledge; this also led them to change their traditional attitude to working alone. In most cases, when faced with problems too difficult for them to deal with alone, they recognized one or two old expert agao to refer the patient to; and in case even these failed, they sent the patient to the hospital. Another substantially revolutionary innovation was the collective training of an apprentice by elders in the gaaru: the payment was shared equally among themselves. Moreover, they wanted to start a botanical garden around the gaaru to have the rarer herbs immediately available for use and keep a jug to store medicines after preparation. They also agreed to have their herbal knowledge improved by having some of their medicines and herbs used to prepare them tested by KEMRI (Kenya Medical Research Institute), the official agency empowered by the Kenyan Government to conduct this work with traditional healers. Unfortunately, both of these two developments failed: KEMRI analysts after collecting the samples never replied and the agao were forced to abandon their gaaru because Kiaya's son claimed back his family land. They thus moved to a new site in Nkarini in 1989, where they tried without success to get a piece of public land from the County Councillor. In fact, on her request for payment, they decided to collect the amount among themselves: however, the still unlicensed members refused to contribute, since they argued that they were being cheated as they could only practice within their locality (for they could not travel far for fear of the authorities).

The negative dynamics produced by this episode caused the group to disband for a couple of years: only some few licensed members continued to meet at a certain tree. This went on until 1992, when the group found a new site in Ubarini where a piece of land was bought from the clan of the chairman through his negotiation. They started collecting the money needed by contributing themselves: but the famine affecting the area at the

time seriously hampered the collection of money. Even the building of the new gaaru by communal labour was delayed by the elderly chairman's serious sickness; he died in May 1993.

KIBUKA GROUP

This was the second group to be formed, initially composed of seven agao who took an oath on 6th December 1985. The first phase of the group (six months) had an analogous course to that of the other group: the leadership of Muchiri Kirimu scandalized the members of the group, to the extent that they alleged he was a dishonest and self-imposed leader and so removed him. Muchiri was then expelled from the group itself; after that, he belonged for some years to the group of Kithino and then, in 1989, he was re-admitted to Kibuka group. The new leader, Gichugu Nkoru, was quite a young mugao, whose fame was known even outside Tharaka territory: many times I personally met patients from the Meru highlands and even from Nairobi at his home. His leadership immediately attracted new young members to the group which reached, in the following years, a total of nineteen members. One issue that initially troubled the group's life was the presence of women in the group: they had been brought in by Muchiri as expert ajukia (midwives) who also knew a bit of Ugao for children. The idea of having women among them did not arouse enthusiasm in many agao, who complained the women had not taken the oath the men had taken. Besides, since these women were either widows or single for some reason, the agao wondered how they could take oath; they were not even sure what had happened to their husbands. Finally, the issue was solved by admitting only one woman (their leader) to the group.

Gichugu Nkoru was very conscious of his own fame, and used to direct the group giving little room for other members'opinions and ideas: and this created a series of internal quarrels that made the life of the group always rather unstable. Moreover, since he was a drinker, he usually attended the meetings drunk and this often made discussion inconclusive. Hence there were two splits in the history of the group: the first took place in 1989 and gave rise to the Muthitwa group; the second, in 1993, gave birth to a sixth group, that of Rwakiemb'ea. Despite being so authoritarian, Gichugu's leadership was rich in new, interesting ideas on how to improve professional work. For example, he wanted to start a proper 'School of Ugao' to train young men in the profession, with a course taking seven years before candidates graduated. The criteria for admission were to have been: having completed primary schooling, being married, and being interested in Ugao. Moreover, the younger and educated agao of the group asked to visit places like hospitals, universities, or institutes such as KEMRI to see how herbal medicines are prepared. This group also wanted to start a botanical garden in which to grow medicinal plants; and some samples were given to KEMRI to be tested. They also wanted to get a pressure cooker and sufurias with tight fitting lids so that they could prepare medicines without losing their medicinal vapour. Another interesting suggestion was the

request made to Nkubu Hospital doctors that they perform postmortems for the agao when their patients died, so that agao could know what caused his/her death - the use of wrong medicines or the severity of the disease. The chairman also showed great awareness of the need not to stop from going immediately to the hospital those patients who were seriously ill and whom they were unable to treat: he often blamed members who, for money sake, had a tendency of keeping patients too long.

However, all these good ideas were never or only partially implemented because of the problems that troubled the internal life of the group and were never properly resolved. Lateness and absenteeism always affected the regularity of meetings; drunkenness created problems of indiscipline and reduced mutual respect during the meetings themselves. An attempt to establish a more ordered running of meetings by electing a meeting chairman had a short life. Both the chairman's autocratic decisions and members' lengthy and fruitless discussions had the only one result - very little effective action. The gaaru which they declared many times they were willing to build, was never built due to a failure to turn up for communal labour. Initially, a house was offered them by the Chief at Tunyai market: but they refused, since they 'could not talk their secrets at the market' (M'Mburuki). Then they got a piece of land owned by the chairman and decided to build there. At this point, however, there were two factions: one which wanted to build the gaaru by themselves and the other one which wanted to give the building contract to somebody either external or internal to the group. The compromise was that they would build the walls themselves and contract out the work of thatching: both tasks took a long time. However, even when it was ready, the intended use made of the gaaru for collective discussion of the most difficult cases, and the exchange of patients among the group's members, remained very limited: their professional activity continued in a substantially individualistic fashion.

The problem of unlicensed members was also particularly felt in this group which was mostly composed of young and very mobile agao accostumed to travelling all over the country for professional purposes. Four members of the group went together to treat collectively a patient in Nairobi, whom they allegedly cured. The chairman also went with another member to Kitui District to exchange knowledge with a Kamba mundu mue (healer).

A watershed in the history of the group is marked by the splitting off of almost half of its members in October 1989. The official reason given was that the Thingithu river, when in flood, prevented those members living on the far side from coming to group meetings. The real reason was that the drunken state and the abusive manners of the chairman had become intolerable to a part of the group and they intended to carry on autonomously. Nevertheless, the polite official reason given for the separation allowed members to avoid any conflict with the chairman who had no objection when confronted with the fact. A final joint meeting was held on 2nd October 1989, during which it was stressed that, even after subdividing, the two groups remained somehow united since they had taken a common oath. The meeting produced an 'official agreement' between the two groups

that included the following clauses: 1) they would not use different names for the two groups (for three years the new group called itself 'Kibuka B'); 2) they would not be enemies; 3) they would continue to operate closely without secrets; 4) they would remember and respect the oath they took together.

After the separation, the original group turned sour: they decide to expel the chairman and continue on their own. They also wanted to build a new gaaru in a different place. However, Gichugu's charisma and his skill in managing social relationships was such that he was soon re-admitted to the group. The group re-started as usual, with its internal rivalries and conflicts but under the unquestioned rule of Gichugu: it formed a kind of personal 'court'. Again there were many fine plans, but very little implementation. This continued until April 1993, when Gichugu died from a liver illness (hepatic cirrhosis).

MUTHITWA GROUP

The little group of the secessionists from Kibuka formed this group in June 1989. They were originally six members, and selected their new chairman and other officials (vice-chairman, treasurer, and secretary) by voting in a democratic way: they were the only group to hold regular polls. They elected Rukungi Mungania as their leader, a person highly reputed because of his great honesty and open-handedness; he was also a government representative, since he held the post of headman in his home area. His frank and wise style of leadership immediately gave to the internal life of the group a flavour of pleasant sociability, profoundly different from the former period. When the group started meeting at their new venue in Muthitwa, the dominant feeling, easily perceptible, was of people really enjoying their meetings and highly motivated. Everybody could contribute to the collective discussion by bringing to it his personal ideas.

With this attitude, the group passed very strict regulations about drunkenness: nobody would be admitted to group meetings when drunk; and if he persisted, he would be expelled from the group. These and other internal regulations were written down by the group's secretary, a literate young person (who could speak a bit of English); he kept regular minutes of the group's meetings from the beginning. Moreover, they immediately decided to build their own gaaru, which they did through communal labour in a short time. Their new meeting centre was inaugurated on 1st August 1989 by a feast, which was attended by the Public Health Doctor from Nkubu Hospital whom they had invited.

The group also showed great concern about health education and hygiene: they built a pit latrine near the gaaru. A member even tried to act as health educator in his home village: but he was stopped by the local headman, who told him he cannot carry on that duty because he was not a recognized 'community health worker'.

The fame of the group brought it five new members, bringing the total number up to eleven. They took an oath of collaboration together with all the other older members of the group. One of the new members was a circumciser, just as the chairman Rukungi

also was: this led the group to tackle the issue of AIDS and the widespread problem of contagion in Africa, and they asked the doctors for a lesson about this and, in particular, on the use of razors, blades and safe medicines to drink.

The internal life of the group has continued without problem and with a great degree of discipline. Attendance at group meetings was fair and each member regularly contributed to the common treasury: in this way they could manage to buy from its owner the piece of land where the qaaru was sited - all this in spite of the serious famine affecting the area. They even improved the contruction of the qaaru, which came to look very solid and durable.

In the meanwhile, one of the oldest of the group's members died, a new young candidate started being trained as a mugao by one of the group's members, and another mugao opened a 'clinic' of his own in Meru highlands.

KAMARANDI GROUP

This group was composed of six members who took their oath on 17 June 1986. All the members were rather old and scarcely active agao, except for the chairman Mukumbu Kabua, a rather tricky and untrust worthy person. Since he was the one who called the others to join the group, he selected them from among those trusty agao he was sure would not question his rule. Moreover, because of his close relationship with the local Subchief, he enjoyed unquestioned power to manage the group as he liked. When, in 1989, a famous and active mugao living in the area (Mang'oro) asked to join the group, he managed to ensure his application failed: he invited him to a meeting where only few members where present, so that no decision could be taken on his application. Then at the next meeting, when discussing the matter with the other members without the applicant being present, he convinced them not to accept him because 'he was usually away from home treating people far away'.

The problem of this group probably lies in the way it was formed: there was no real intention of development, at least in its first stage. It was just because the leader had heard of what was going on among the other Tharaka agao, and he did not want to be left behind that he decided to form a group in his home area. However, he always seemed scarcely bothered by the group and was inactive in fostering its development. The consequences for the group's life, during its first six years, were quite evident: group meetings were very irregular, lateness and absenteeism constantly affected the group, which seemed very disorganized. This was evident in the group's failure to implement for years its decision to build a qaaru as the other groups had already done: many times they started but every time they failed because of the laziness of the group's members. Even the attractiveness of the group for new, younger members was limited: only one young man wanted to be trained and, after some time, he abandoned the group.

Things improved a little after 1992 when the group was re-organized after a period of latency. Since some of the oldest

members had died, some new younger members were accepted into the group, which thus increased its membership to seven people. The new group decided to finally implement the decision to build their gaaru: they bought a piece of land from the chairman by contributing money themselves (in spite of the famine) and in a few months were able to construct a nice building as their meeting place. The group looks now much more united and concerned with its development. The meetings are regular and well attended though what is still lacking is any flow of new ideas or a spirit of innovation which inspires other groups.

KAMANYAKI GROUP

This group was originally composed of eight members who took their oath on 12 March 1986. It is the only group who included among its members a muringia, Mukwaiti an old and famous diviner. The involvement of the diviner was explicitly requested by some agao who did not perform uringia and wanted to know 'the reason why their patients were suffering from illness'. The age and fame of the woman made her presence unquestioned by the others; however, she always sat silently on one side when attending group meetings.

This group is quite atypical, since its problem has always been the weak leadership of its chairman Nkoru Mwenda. He is a young mugao whose authority was never respected at all, especially by the oldest agao in the group. However, since he was literate and the majority in the group were young people, he could maintain his leadership uneffected. Nevertheless, the relationship between younger and older members has always been particularly problematic in this group. The lack of an authoritative leadership has been evident from the beginning, when problems of absenteeism, lateness and laziness started to affect the group's meetings, which have always been rather irregular. The issue of the meeting-place is particularly significant: this group was the first to decide to build a gaaru to be used as a centre for the group. However, the decision was never implemented for years, since most of the members did not participate in the communal labour as promised. Besides, it became clear that the piece of land occupied by the group was disputed by the neighbour, who was accused by the agao of having stolen the poles they had cut for the building. In 1992 the group moved to a new piece of public land they had obtained from the County Councillor: however, the construction continued very slowly and, at present, is still going on.

Apart from this, the group was affected by another serious problem. A group of agao who had not joined the group, probably out of of envy for the new status acquired by at least some of the group's members who had received the Government certificate, started systematically disturbing the work of the group, to the extent of trying to sabotage the therapeutic work of the group's members by discrediting them. The agao claimed that their patients in many cases were being bewitched at night after they had been treated during the day. The sorcerers were invited to enter the group in order to stop their activity; but they

refused. The problem was reported to the local Subchief who first intended refer the matter to the court, but then, probably because of some pressures, changed his mind, to avoid, he said, 'to further worsen the internal tensions in the community' (personal conversation). This problematic relationship with their external colleagues certainly influenced the same group's life: at least some of the members were afraid to show themselves at the group's meetings, which they thought were being spied on.

To understand this group's problems we must take into account its situation in one of the poorest and most arid areas of Tharaka land, where famine is an almost chronic problem. Here the importance of a professional grouping is still a rather remote concept, which most of the agao (especially the older ones) do not understand. The mugao's work is still quite individualistic and independently carried out, even among group members: only a few of them had started referring to each other the most difficult cases. This can perhaps explain the low level of collaboration within the group and the lack of trust between older and younger members. Moreover, the group did not attract others in the area: only three new members ever joined the group and no young apprentice was ever trained. One of the reasons given by the agao is the strong presence of the Pentecostal Church in the area, whose pastors are particularly opposed to traditional healers and their practices.

Finally, of some interest is the fact that two young literate members of the group have started keeping regular records of their patients, registering their number, the problems diagnosed and therapy given.

RWAKIEMB'EA GROUP

Since this is a newly formed group, composed of two members who left the Kibuka group in June 1993 and joined some other agao from their home area in Iruruma village in Central Tharaka (Marimanti Location), detailed information on it is still not available. However, the group's location is particularly significant as it suggests that a process which started in South Tharaka is now steadily expanding throughout all the Tharaka agao independently of any further external influence.

APPENDIX J

The Role-analysis Approach

This approach was followed in the Tharaka Rural health Care Project in order to foster cooperation at the community level. It has two aspects: 1) to discuss and identify community health needs, determining the priorities to be pursued; 2) to single out all the health resources locally available to tackle these problems. The first aspect encompasses areas of community development such as water, sanitation, immunisation, irrigation, food production, storage and preparation, or income-generating projects. The second aspect (the most important for our issue here) entails the singling out of all the individual and organizational health facilities used by people in the area, either indigenous or biomedical, and the analysis of the different role distinguishing each of them. The discussion on this second aspect was usually the most interesting and lively: whereas the existence and the work of the ajukia (traditional birth attendants) was always aknowledged with no particular problem, it was not the same with the agao. Most people were afraid and embarassed to discuss matters pertaining to Ugao publicly, even though they admitted that a majority of people were usually treated by the agao. Some people made their difficulty explicit by saying that agao dealt with multiple forces other than physical ones: the distinction which existed in their minds between the two levels of illness (Cf. Ch.3), brought them to consider the agao's work as not pertinent to strictly 'medical' issues. However, they accepted their involvement because of the herbalistic aspect of their work, considered as involving materia medica. It was not a simple task to identify similarities and differences among the various roles involved: most people failed to grasp the distinction between Village Health Committee members, Community Health Workers, Traditional Birth Attendants and Traditional Healers. The issue was solved by examining the simple tasks performed by each role, by aggregating them into wider activities and then these into more general functions, so as to obtain the 'Roles-description Chart' reported in Chart L.1 with regard to health care workers at the community level only (biomedical personnel at the intermediate and district level are excluded).

This role-analysis approach allowed us set priorities for training different roles, both in terms of health needs and of areas of needed knowledge and techniques. In this way the contents of the training were not 'ready-made', but established on the basis of villagers' views and attitudes (even though as structured by the anthropologist). Regarding the TBAs and the traditional healers in particular, the training contents were further specificated directly with them later on. The selected community health workers underwent a three-week course in three stages between 1988 and 1989 about prevention, sanitation, hygiene, nutrition and house-keeping. Later on, the exercise was repeated in four other areas: Ubarini, Mwerera and Gakurungu in Tunyai Sublocation and Nkarini in Chakariga Sublocation.

Fig.3.1 ROLES-DESCRIPTION CHART (Health Care Resources at the Community Level)

ROLES	FUNCTIONS	ACTIVITIES	TASKS
Community Health Workers (CHWs)	Health Education and Promotion	Home visiting	Check and improve: hygiene, sanitation, cleanliness and nutritional levels
	Prevention	Monitoring of immunization levels	Check and improve immunization in the families
	Linkage between community/health care facilities	Referral of serious cases	Organize patients flow Follow-up of cases after treatment
	Health Information	Collection of basic health information	Reports on birth, deaths, and illnesses prevalence
Traditional Birth Attendants (TBAs)	Assistance and advice on antenatal, delivery and postnatal care in labour	Advice and monitoring of pregnancies Assistance of deliveries Advice and assistance of post-natal care and child welfare	Visit and support of pregnant women Attend to deliveries and support women in labour Education and support of women during puerperium Monitoring of child nutrition and growth
	Linkage between mothers/health care facilities	Referral of complicated cases	Organization of mothers flow to mobil clinics Follow-up at home
	Family Planning and Spacing	Improvement of family planning and spacing attitutes	Education of mothers Supply of contraceptives and advice on other techniques

Traditional Healers (TH)	Diagnosis and Treatment	Herbalistic treatment of illnesses	Preparation and administration of herbal concoctions
		Treatment of mental problems	Ritual therapies
	Education and Prevention	Integration of treatment education/prevention advice	Patient education and advice
	Linkage between patients/health care facilities	Referral of difficult cases	Sending patients to health care facilities by referral cards
	Herbalistic Drugs Research	Collaboration in drugs research	Testing of herbs and concoctions by national research institutions
Village Health Committes (VHCs)	Community Involvement and Participation in Health Care	Identification of health problems and needs	Discussion during committe and public meetings
		Community mobilization and organization	Support to the work of CHWs
	Supervision of CHWs and TBAs	Selection, training and monitoring of CHW and TBAs	Identify volunteers and expert TBAs
			Arrange training and organize periodical supervision
	Integration between Health Care and other Development Projects	Coordination of health care activities with other development sectors	Represented in the Sublocation Development Committee
			Discuss projects coordination in public meetings

APPENDIX K

PAR Methodology and the Researcher's Role

K.1 PAR Methodology

The substantive material for this dissertation was collected during fieldwork among Tharaka carried out within the broader framework of the 'Tharaka Rural Health Care Project' (THARHCAP), a joint venture between the Department of Sociology of the University of Bologna and the Department of Community Health of the University of Nairobi, with the Italian NGO CUAMM (International College for Health Cooperation in Developing Countries) and the sponsorship of the Italian Ministry of Foreign Affairs. The project was located in South Tharaka Location (Tharaka Division, Meru District), an area with 12,869 people (1979 Kenya Census). Its object was the cultural dynamics of health development, particularly the interrelationship between biomedical health care and Tharaka traditional medicine within the local community.

The CUAMM NGO has staffed with doctors and other biomedical personnel the missionary hospital of Nkubu since 1955: during the main research period,six physicians and two physiotherapists were present. In the catchment region of the hospital, Tharaka represents a significant, under-served area: it has no hospital and no doctor, and very few health centres and dispensaries (Cf. Ch.2).

The research project focused particularly on the Tharaka area of activity of CUAMM: its aim was to foster an ethno-development process (Eghbal,1987; Stevenhagen,1987), intended as a way of finding within the community's own culture the resources and the creative forces necessary to confront the challenges of the modern changing world. In the health domain, in particular, this means self-determination of the community's health needs, and people's participation in the decision-making bodies and processes where the allocation and functioning of health care facilities are discussed and decided.

In order to achieve these aims, a particular methodological approach was used, namely 'Participatory Action Research' (PAR): it is a type of action-research that emerged from the work of social scientists in the developing countries of Africa,Asia and Latin America (Fals Borda,1979; 1981; Mustafa,1981; Tandon 1981). Such methodology developed in response to the call for communities to be assisted in gaining more control over their lives, after having seen so many conventional researchers come into and go out of the community without ever explaining the purposes of their studies.

PAR methodology wants to be fundamentally different from conventional approaches to research and development intervention. In the latter, the researched perform the role of "objects" in research or development; in PAR, the researched are subjects

(Moser,1977; Oquist,1977). Through PAR methodology, in fact, the researcher attempts to help the community understand their situation better and work out solutions together, using local initiatives and resources as much as possible. External resources and expertise are not considered primary in solving community problems: they are used only as supplements when needed to be available for the mobilization of people's own resources and skills.

Like other action-oriented paradigms, PAR has four main characteristics (Price and Politser,1980:6-8):

a) it focuses on the study of social problems; this does not imply that the development of theory is irrelevant: on the contrary, maintaining a problem-focus is viewed as a strategy for developing and testing theory as well as for solving practical problems;

b) practitioners rather than researchers generally assume responsibility for solving such problems; this is why action researchers - whether working outside or inside a practical setting - seek to collaborate with practitioners;

c) it attempts to achieve the dual goal of developing new knowledge and solving practical problems;

d) it stresses the actual use and dissemination of the research products; this is achieved by establishing collaborative relationship with client system and by working with practitioners in defining the scope, goals, and methods of research.

With these characteristics in mind, two basic considerations suggested the use of PAR methodology in TRHC Project. Firstly, findings of prior studies on indigenous medicine in Kenya did not have any significant impact on health development of local communities; secondly, the study of traditional medicine had little influence on the thinking and behaviour of biomedical personnel. The use of PAR methodology was thought necessary in order to lead to specific behaviour and attitude changes among both health workers and the community: the changes brought about should be those which are considered conducive to health improvement.

Therefore, it was planned that using an anthropological participatory action-oriented approach we were to facilitate a process of change in the Tharaka community through self-education for health; promote communication and interaction between indigenous health practitioners and hospital-type health personnel; achieve a creative interaction between Tharaka indigenous care and Western biomedicine; experiment with and formulate further a new praxis for collaboration between behavioural scientists, health practitioners and the community.

Three different methodological levels were singled out within the general application of PAR as a heuristic strategy, and integrated in field work:

a) the cognitive level, regarding more strictly the research work

and its results, mainly pertaining to the researcher and his assistants ;

b) the intervention level, regarding the application of cognitive results to the specific situation in order to modify it, mainly pertaining to project actors (C.U.A.M.M. doctors and other Kenyan biomedical personnel);

c) the action level, regarding the initiatives put into action by local social actors directly involved in the situation, mainly pertaining to Tharaka health practitioners and their community.

I argue that the failure of most development projects is due to the fact that they limited themselves to the first two levels, without taking into account the third one, the most important for setting in motion a real self-development process. For this purpose, during and at the end of each project phase, workshops involving the community, indigenous healers, biomedical personel and the researcher were held in the field: their purpose was to present data collected and discuss solutions to health problems identified from the continuing study. Separate meetings were also held between the researcher and the medical personnel at Nkubu Hospital, discussing the ethnographic reports provided by the former to them.

Given the limits of this dissertation, it has not been possible to consider all the research findings achieved by the THARHCA Project: therefore, I have deliberately focused my attention only on one particular aspect of the project, namely the professional developments of Tharaka healers. Consequently, most of the methodological problems raised by PAR approach have necessarily been taken for granted; while their specific implications for my research focus have been briefly discussed.

K.2 Rethinking the Researcher's Role

The PAR approach delineated above necessarily implies a re-thinking of the traditional role the researcher plays in the researched situation. In the past, non-Western societies were often treated as mere objects of research by anthropologists forgetting their shared humanity. Re-thinking the subject/object relationship in the research situation entails, among the other things, a widening of the spectrum of roles commonly played by the researcher. In the Tharaka case, this has meant I had to perform at least four different functions at once, all equally part of my research role using a PAR approach.

1) The traditional investigative role, using the classic 'paraphernalia' any anthropologist must bring with him in the field (schedules and field-notes for participant observation, outlines for ethnographic interviews, check-lists and maps for case-studies, etc.). At the very beginning, one of the main

problems I faced in collecting data about the health care domain in Tharaka was to distinguish, in people's perception, my image from that of medical doctors. That a white man could be interested into medical domain without taking care of their malaises appeared strange to many Tharaka people. Thus, many times I had to comfort the pain of afflicted people, in spite of my professional explanations which sounded totally out-of-place in many occasions; and to give a lift to seriously ill persons willing to go to the hospital from the most remote areas of Tharaka, where unpassable roads never saw a single vehicle for weeks. However, it was just in such inland areas of Tharaka, near the Tana river, in Kamanyaki Sublocation, that my personal contacts with both health practitioners and common people were characterized by a feeling that went well beyond a basic atmosphere of respect and assumed the features of mutual sympathy and trust. The fact that I slept for some months in a hut which the local Sub-chief kindly hired me certainly was fundamental to all this. I still remember with great pleasure the suppers spent in front of my hut chatting with the Sub-chief's family, his relatives and some curious onlookers in the total darkness of the bush; and the wandering up and down from one homestead to the other one, over hills covered with thorny scrub; or the many times I was offered nchobi, the local sugar cane beer, to drink in any male assembly - a rather unique chance to really come to know this and that about everybody and hear people's actual opinions.

As for the problem of language, I had two interpreters, in two different areas (Tunyai and Kamanyaki) who acted as local research assistants; all the interviews were recorded on tape in Kitharaka language and then written out in two versions (Kitharaka and English) by my two interpreters. After that, I had a Primary School headmaster with some anthropological interests who acted as a supervisor of the translated material: my first-hand discussions with him about the raw material collected were very useful for my subsequent deeper analysis. Moreover, I studied for some months Kimeru language (of which Kitharaka is a variant) with Father Favaro, an old Italian missionary who had been in Kenya some fifty years: and this, at least, allowed me a better understanding of both basic expressions and idioms in the local languages.

2) The apprentice role: in every culture there are domains which can be freely investigated and easily known and understood; others that are jealously hidden from lay and foreign eyes. The Tharaka Ugao is certainly a domain of the second type: and the secret represents an essential element of its professional nature. Neither systematic discussions and interviews nor intensive observations alone would have enabled me to penetrate the depths of the internal structure of Ugao beliefs and practices: when, after almost a year of field work, I fully realized this, I decided to accept the veiled proposal of three of the agao I was working with. So my apprenticeship as a mugao started under the mastership of one of oldest and well-known Tharaka agao, M'Mburuki Muthia, and his two assistants, two younger but already expert agao, Nkoru Mwenda and Rukungi

Mungania (who latter became the chairman of Muthitwa group). It lasted over a period of more than six months, during which for seventeen intensive days I was taught the foundations of the Uqao beliefs and ritual practices. The nature and the range of the etiological system was disclosed to my eyes; the meaning and the performance of the main therapeutic rituals were taught me. A short final practical apprenticeship with real or pretended patients was an extremely useful part of the course to better understand the work of the Uqao in action. Though I am fully aware of the fact that in its teaching method the course did not completely follow the traditional way (since the shortage of time required intensified teaching, by a question-and-answer method, for example), I am fully convinced of the genuine character of the contents I was taught. Later on, I had the chance to compare the elements I was taught with the work of other aqao, and I found a substantial correspondence. My only regret remains that, because of lack of time due to other research duties, I was unable to complete the teaching as I wished; I could have widened, in particular, the part regarding the various types of urogi (sorcery) and of kurogora (counter-sorcery) rituals used to treat them.

3) The consultant role: the applied nature of the THARHCA project required the researcher a supplementary skill: by performing the two roles of investigator and apprentice, to translate continuously the research findings collected at the cognitive level into the intervention level. Obviously, this was not always possible; and, sometimes, the contradictory nature of certain findings made this translation simply inappropriate. When this operation proved successful, the possibility to show concretely to project staff (doctors and biomedical personnel) the practical utility of the anthropological research, greatly improved mutual understanding. The interdisciplinary approach needed for the success of this operation was, in fact, a challenge to cross the well consolidated fences of both the medical and the human sciences, in order to find a common language to talk, rather than any concept to share. This was really fatiguing work, that took some time: however, the results were rewarding, both in terms of inter-professional relationships and applied outcomes. Most of the doctors, initially rather skeptical about the work, later showed a great degree of interest and were personally involved in the work with Tharaka agao (healers) in the clinical cases they jointly followed.

I must confess that, if the other roles were for the most part very interesting, at intervals exciting, this one was very stressful; and the emotional and relational components were fully part of it, no less than in the other roles.

4) The cultural broker role, acting as a go-between the project staff and the Tharaka practitioners and the community as a whole. The articulation of the intervention level with the action level in PAR methodology makes this role particularly important and delicate: to make two distant worlds mutually communicate and jointly act is not an easy matter. To simplify it, I developed

and implemented a three-stage strategy: firstly, the 'exploratory contact', to enable the parties get acquainted with each other and confident; secondly, the 'in-depth study', to deepen people's knowledge of each other and clear up any prejudice; and thirdly, the 'implementation stage', when time was ripe to start some kind of interaction at the operational level, with practical results (village health committees, joint follow-up of clinical cases, workshops, etc.). The main difficulty of this role was to maintain a clear balance between the two levels it was supposed to join, avoiding taking any leading part in the interaction. In many instances there was a strong temptation, if only to fill the gap existing between them. Therefore,I had to watch and continously control my subjectivity, leaving the actors involved in any social situation 'to play the game' as they liked. Curiously, in many cases most of the 'resistance' to change did not come at the action level but at the intervention one. When, during my first interviews, I discussed with the agao the idea of linking them in groups to start cooperation with biomedical personnel, almost all of them agreed enthusiastically; this was not the case with the most of the doctors and other biomedical personnel. So sometimes I had the impression that the two levels were exactly reversed; and that it was the action level which was driving the intervention one (this , by the way, demonstrates that when an agency starts a new project, its field workers' view of it does not necessarily coincide with that of the headquarter staff).

The variety of roles subsumed within the same person sometimes was very hard to perform: as in any form of role-set, the problem of role-strain was a constant danger. The tug of requests and loyalties in some situations became a real challenge both to the intelligence and diplomatic ability of the researcher. I have already mentioned I could not complete my apprenticeship as a mugao as I wished because of my other research duties; I should add that even the performance of the brokerage and consultancy roles on some occasions caused me internal conflict, mostly because of my steady friendly relationship with the agao. As not a detached, but an actively participant observer, I felt the psychological strain of simultaneously living in two different worlds and of being, at least partly, alienated from both. I am not sure at all of having been able to deal with this role strain in the best way every time I faced it; but I like to end these considerations on my role as a researcher by mentioning the meaning of the local name I was given by Tharaka people during my stay in Kamanyaki: M'Kamwara. It means, in Kitharaka, 'the one who does things well and smoothly'. Was it the key to my role I was looking for?

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